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ESSEX COUNTY, NY

COMMUNITY HEALTH ASSESSMENT 2019

COMMUNITY HEALTH IMPROVEMENT/SERVICE PLAN 2019-2021

Essex County Health Partners

Report Date:

December 31, 2019

Foreword

Essex County Health Partners are proud to present this report:

Essex County, NY Community Health Assessment (CHA) 2019 and Community Health Improvement/Service Plan (CHISP) 2019-2021.

Significant attention was given to creating a report that is not only informative to the lead agencies engaged in the assessment, but one that is useful to a wide variety of individuals, groups, and organizations. This is because in order to improve the health of communities, the whole community must engaged.

This report continues a long history of data gathering and analysis from a variety of sources including local, regional, state and national entities. It includes primary and secondary data; as well as quantitative and qualitative data.

Several components of this assessment are improvements from previous assessments. The enhancements include:

- Integration of input from local residents and community stakeholders;
- Consideration of health by sub-population;
- Identification of disparities in health by sub-population;
- Examination of local social determinants of health; and
- Identification of community assets that can be mobilized to improve the health of our community.

Additionally, higher levels of engagement were achieved through intervention planning efforts from previous assessments. This includes:

- Convening work groups to review health outcomes and contributing factors
- Engaging partners to evaluate contributing factors to determine true root cause(s) that lead to poor health outcomes and disparate health indicators in certain communities, groups, locations;
- Working to examine the existing assets/programs/initiatives; and
- Collectively selecting the strategies that are most likely to result in measurable health gains; address the disparities identified; and be implemented successfully among partners.

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Executive Summary

Executive Summary

PART I: Introduction

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Introduction

The purpose of the Essex County, NY Health Community Health Assessment (CHA) 2019 and Community Health Improvement/Service Plan (CHISP) 2019-2021 is to demonstrate an ongoing understanding of the significant health needs of Essex County residents and actions necessary to address these needs.

Needs were identified through a comprehensive analysis of multi-source data, community perceptions, and a solid historical knowledge of the region, cultivated after years of interacting with individuals and families in the county by the service agencies referenced in this report.

Partnerships

Essential to the development of this assessment and planning effort was the use of a collaborative process model – the **County Health Rankings and Roadmaps** Take Action Cycle – which emphasizes communication and working together with broad representation of community sectors.

Identified as ***Essex County Health Partners (ECHP)*** are Essex County Health Department (ECHD), University of Vermont Health Network – Elizabethtown Community Hospital (UVMHN-ECH), and Adirondack Health – Adirondack Medical Center (AH-AMC). To achieve effective collaboration, ***ECHP*** frequently engaged with each other and with the Adirondack Health Institute (AHI) Adirondack Regional Health Network (ARHN), as participants of a seven (7) county multi-stakeholder coalition. ARHN's purpose is to coordinate data collection, conduct regional stakeholder surveys, inform analysis and prioritization methods, and set regional priorities and initiatives.

Essex County Health Partners maintained this effort on a scale focused in Essex County to engage local partners in further isolating trends, issues, and concerns most important to constituents. Informing this process through the expertise of a broad cross-section of representation from various sectors in the community are the members of the following six committees/coalitions: Population Health Committees at both ECH and AMC, the Public Health Advisory Committee (PHAC), Essex County Human Services Committee (sub-committee of the Essex County Board of Supervisors), Community Service Board, and the Adirondack Community Action Program (ACAP) Human Services Coalition. The longstanding relationships, ongoing communication, and collaboration on shared initiatives between the local health department (LHD), hospitals, community based organizations (CBOs), and stakeholders helped refine CHA data and led to clear asset determination and selection of partners that best fit the interventions chosen in the CHISP.

Data Sources

The data used to draw health needs conclusions and advise strategy development originated from multiple primary and secondary sources. Secondary data included a regional survey containing responses from 129 different Essex County stakeholders, launched and reviewed by ARHN, resulting in a final report evaluated by ECHP. Additional secondary data included ARHN Health Indicator and Community Profile Data Sheets, compilations and analyses of hundreds of data indicators from various sources.

Essex County Health Partners advanced a deliberative process to generate new primary data and to refine secondary data through distributed focus group surveys, community surveys, asset matrix conceptualization, and the evaluation and synthesis of reports from various local agencies. The distributed focus group initiative involved five (5) groups of stakeholders, totaling 49 individuals. The community survey garnered 354 responses, and the asset matrix categorized over 100 individual organizations, agencies, programs, or services that could be called upon to support ***ECHP*** interventions.

Locally Identified NYS Prevention Agenda Priorities & Disparities

Following an iterative process of: reviewing and analyzing the data described above; conducting a regional and local prioritization process via utilization of a matrix to flesh out need/feasibility perceptions; sharing preliminary findings and requesting follow-up input from local stakeholders and community members, a final scope emerged.

Working within the 2019-2024 New York State Prevention Agenda framework of five action areas, the following three action areas were selected by ***ECHP***:

- Prevent Chronic Disease
- Promote Healthy Women, Infants, and Children
- Promote Well Being, Prevent Mental Health and Substance Use Disorders

Disparities were identified within the CHA report for specific health indicators in Section 1 and within sub-areas of each domain of Section 2. These include, age, gender, specific geography/communities, and socio-economics.

Access to healthcare was identified as a cross-cutting disparity for Essex County residents with barriers being provider shortages, geography, and transportation.

The two remaining Prevention Agenda action areas <u>not selected</u> for CHISP integration are:

- Promote a Healthy and Safe Environment and
- Prevent Communicable Disease.

Though not captured in the CHISP, it is important to note that activities, programs, and initiatives are being delivered in these areas.

Locally Identified Interventions to Address Priorities & Disparities

The process to select strategies that address the priorities and disparities identified above occurred by leveraging existing hospital/ECHD committees, and convening priority area workgroups with other community partners.

Committees and workgroups were presented with the CHA findings, a preliminary analysis of the data relevant to the issue, and a list of potential evidence-based solutions to consider. The groups further assessed data using partner expertise gained from working within the priority area being evaluated. The discussions centered on drilling down to the true root cause(s) that lead to poor health outcomes and disparate health indicators in certain communities, groups, locations; evaluating existing assets/programs/initiatives; and selecting the strategies that are most likely to result in measurable health gains; address the disparities identified; and be implemented successfully among partners.

A summary of the CHISP interventions are listed in the tables below.

Focus Areas	Intervention	Lead	Partners
PRIORITY: CHRONIC DISEASE			
Healthy Eating & Food Security	Worksite nutrition & physical activity programs	UVHN-ECH	
	School-based obesity prevention	ECHD	Schools
	Increase the availability of fruit & vegetable incentive programs	UVHN-ECH	ECHD
	Food insecurity referral	ECHD / UVHN-ECH	AMC
Tobacco Prevention	Facilitate medical / behavioral practices in delivering tobacco treatment	NCHHN	UVHN-ECH/AMC
	Health communications & marketing to promote tobacco use treatment	ECHD / UVHN-ECH	Media
	Encourage healthcare provider involvement in patient quit attempts	NCHHN	UVHN-ECH/AMC
	Promote smoke-free housing	CVFC	
	Increase smoke-free parks/playgrounds	CVFC	
Chronic Disease Prevention & Care Management	Systems change for cancer screening reminders	UVHN-ECH/AH	
	Media to build community demand	UVHN-ECH/ECHD	Media
	Provider assessment & feedback on screening services	UVHN-ECH	
	Remove barriers to screening	UVHN-ECH	
	Access to health insurance to increase screening	UVHN-ECH	
	Improve detection of undiagnosed hypertension	UVHN-ECH	
	Promote testing for pre-diabetes/diabetes	UVHN-ECH/AH	
	Team approach to chronic disease outcomes	UVHN-ECH/AH	
	Referral for those with pre-diabetes to DPP	AH	NCHHN
	Expand access to CDSM	AH	
	Expand access to NDPP	UVHN-ECH/AH	NCHHN

Focus Areas	Intervention	Lead	Partners
PRIORITY: WELL-BEING/MENTAL HEALTH/SUBSTANCE USE DISORDER			
Promote Well-Being	Social/emotional support across a lifespan	UVHN-ECH	
	Resilience for people living with chronic conditions (LEAD)	ECHD	
	Promote inclusion, integration and competence	AH	
Mental and Substance Use Disorder Prevention	School based prevention: Life Skills Training	Prevention Team	Schools
	Trauma-informed approaches into prevention programs (BRIEF/MindUp)	EC Mental Health	
	SBIRT	UVHN-ECH	
	Integrate trauma-informed approaches and responses	UVHN-ECH	
	Availability/access to MAT	UVHN-ECH	
	Availability/access to OD reversal	AH	St. Joseph's
	Prescriber education regarding opioid guidelines/limits	AH/UVHN-ECH	
	Safe disposal sites & take-back days	AH/Alliance for Positive Health	
	Integrated nicotine / mental health treatment	AH	

Focus Areas	Intervention	Lead	Partners
PRIORITY: HEALTHY WOMEN, INFANTS, CHILDREN			
Maternal & Women's Health	Health insurance enrollment	AH	
	Reproductive goal setting in routine health visits	AH	
	Capacity and competencies of local maternal and infant home visiting programs	ECHD	
Child & Adolescent Health	Oral health messaging in programs serving WIC	ECHD	ACAP/Media
Cross-cutting WIC	Collaborate to address social determinants of WIC (Maternal Health Agenda)	ECHD	AH/UVHN-ECH

Evaluating Impact

Interventions in the CHISP include an array of strategies to improve population health for people of all ages including:

- Coalitions and other community planning efforts;
- Policy, systems and environmental changes;
- Public health marketing and campaigns;
- Outreach, education, training and technical assistance;
- Delivery of early detection and guideline-concordant health care; and
- Application of new technologies in healthcare and improved care coordination.

Examples of Process Measures included in the CHISP are:

- Number of trainings provided
- Number of media campaigns & engagement
- Number of policies revised and updated
- Number of health practices screening and referring
- Number of smoke-free housing unit, parks and playgrounds
- Implementation of updated guidance related to priority areas
- Implementation of new technologies for care delivery
- Number of programs offered & residents served

Essex County Health Partners and the community-based organization partners engaged in the planning of the CHISP have pledged on-going commitment to the health and well-being of Essex County residents. Minimally, ***Essex County Health Partners*** will meet quarterly to:

- assess progress on activities,
- identify barriers to the implementation of activities, and
- develop strategies to overcome barriers and/or determine how activities may be adjusted for success.

The Lead Partner for each activity will document progress through quarterly work plan updates and a representative of ***Essex County Health Partners*** will submit a quarterly update to NYSDOH.

PART I: INTRODUCTION

Executive Summary

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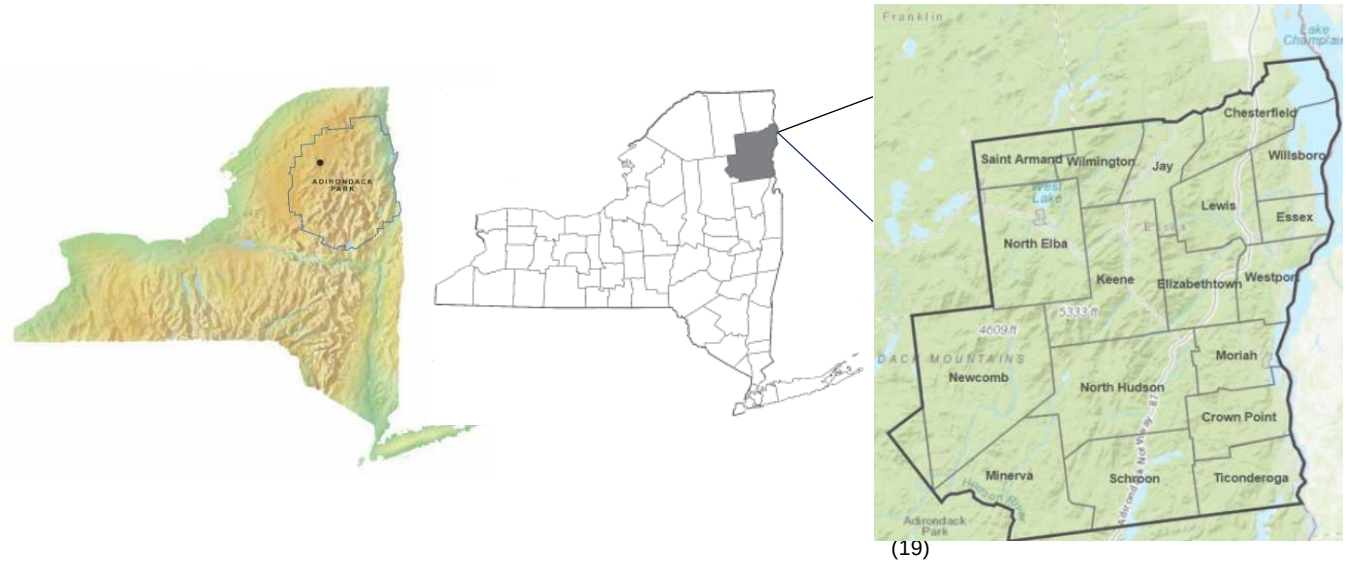
County Snapshot

Geography (4, 19, 63)

Essex County is the 2nd largest county in New York State geographically, and the 3rd least densely populated. The county includes 18 Towns and two (2) Villages. One of the villages, Saranac Lake, is situated partially in Essex County and partially in Franklin County to the west.



(19)

Essex County is the only county in the state situated entirely within the Adirondack Park – 6.1 million acres of public and privately owned land, corresponding with the border of the Adirondack Mountains. The park use is regulated by the Adirondack Park Agency, "ensuring the preservation of more than 10,000 lakes, 30,000 miles of rivers and streams, and a wide variety of habitats, including wetlands and old-growth forests".

The county boasts a solid agricultural base, ample natural resource amenities, and small-town appeal in the various villages and townships spread throughout its borders.

Located in the north-eastern corner of the state, about an hour from the international border with Canada, the economy is dependent on federal/state government and recreation jobs.

Demographics (63)

The population has declined about 5% since the last census in 2010, with approximately 37,300 residents calling Essex County home. Of that, 23% are 65 years or older, 27% are disabled, and 10% are veterans. The population is approximately 93% white, although increasingly diverse, with minority populations constituting 7% of the makeup of the county. Additionally, there is a growing Amish community, with approximately six (6) large families settling in the Champlain Valley region.

The median income is about $55,300, with unemployment averaging 3.2%, and 9% living below the poverty line.

Health

The region is challenged by a high incidence of chronic disease, with obesity, diabetes, and smoking-related illnesses being top concerns. Access to health care is a crosscutting priority, as Essex County holds three health professional shortage area (HPSA) designations: Primary Care and Mental Health (related to geography) and Dental Care for the low income population.

According to the 2019 County Health Rankings and Roadmaps, Essex County ranked 10 out of 62 counties in New York State for Health Outcomes and 13 for Health Factors. Refer to Part II of this report for a more in-depth analysis of the social landscape factors in Essex County that contribute to health and well-being.

Political Affiliations and Governance

Politically, Essex County is considered a swing county – voting for George W. Bush in the 2000 and 2004 elections, Barrack Obama in 2008 and 2012, and Donald Trump in 2016 (16). Prior to 1996, Essex County was staunchly Republican, voting for a Democratic Presidential candidate only once since the Civil War (67). Of the 26,307 registered voters in the county, 11,733 are Republican, 7,055 are Democrat, and 2,029 are Independent (56).

Essex County is governed by a Board of Supervisors, with 18 Town Supervisors serving as board members. Currently, the board includes 12 Republicans, 5 Democrats, and 1 Independent. In 2020, this will shift slightly, with 11 Republicans, 4 Democrats, and 3 Independents comprising the board.

Political affiliations and responsibilities to the voting constituency can present challenges for advancing public health priorities at the local level; however, Essex County residents have enjoyed a strong leadership commitment to health initiatives overall. For example, in 2018, Essex County lawmakers approved a bill outlawing the sale of tobacco products to anyone under the age of 21, prior to the state adopting the measure in July 2019.

This political profile – Republican majority - is in contrast to the current New York State government, where the governorship, House Assembly and Senate are all controlled by the Democratic Party. (35)

Several state-wide legislative initiatives have been passed recently that stand to have a significant impact on public health practice and outcomes. These include, but are not limited to:

- Removal of non-medical exemptions from school vaccination;
- Lead Poisoning Prevention Mandate (lowering actionable elevated blood lead level from 10 mcg/dL to 5 mcg/dL);
- Update of the Adolescent Tobacco Use Prevention Act (ATUPA) increasing the minimal legal sale age of tobacco and e-cigarettes from 18 to 21 years;
- Temporary ban on flavored e-cigarette liquids;
- Package of bills to help address the heroin and opioid epidemic, as well as prescription drug abuse. (69)

Understanding the circumstances in which people live in Essex County informs the Community Health Assessment giving more in-depth meaning to the data and health indicators reviewed. The remaining sections in this part of the report describe the rationale, governing documents, and the process that provided the framework for conducting this assessment and devising the improvement plan.

Purpose

The purpose of the Community Health [Needs] Assessment (CHA) is to learn about the community including the:

- health of the population including priority health issues;
- contributing factors to health risks and outcomes; and
- community resources and assets that can be mobilized to improve population health.

This comprehensive CHA is the basis for the Community Health Improvement/Service Plan (CHISP); a later Part of this report.

Guidance, Requirements and Standards

NYSDOH Guidance

This CHA is informed by guidance provided in the New York State Department of Health (NYSDOH) Prevention Agenda (48). The Prevention Agenda is the state's health improvement plan and serves as a blueprint for local action to improve health and well-being for all and promote health equity in populations experiencing disparities. It provides resources for data collection and analysis and includes standards of adhering to evidenced based interventions.

This CHA is designed to meet requirements as set forth in the NYSDOH Article 6-State Aid for General Public Health Work Program Guidance Document for Community Health Assessment and Community Health Improvement Plan for local health departments and similar needs assessment requirements for hospitals.

Federal Requirements

This CHA follows guiding principles of the federal Affordable Care Act's provisions applicable for non-profit hospitals seeking federal tax-exempt status.

National Accreditation Standards (57)

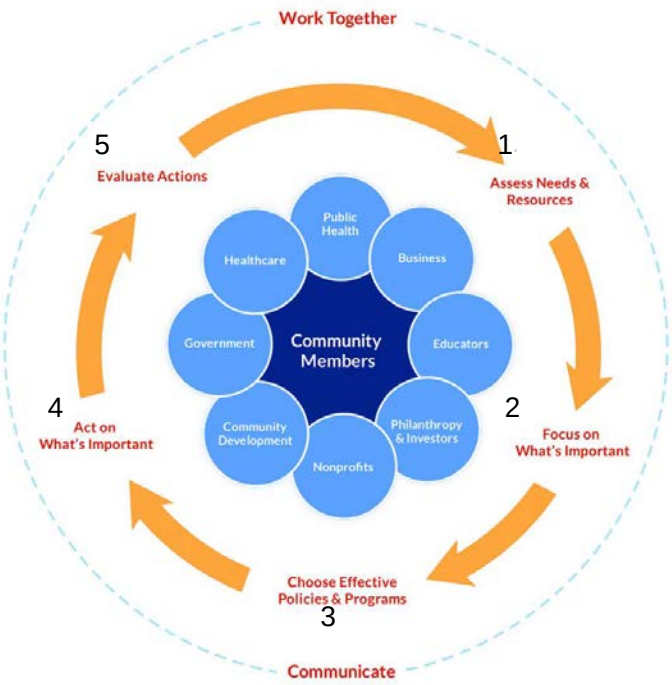
This CHA has been conducted in a manner that meets Public Health Accreditation Board (PHAB) standards; Version 1.5.

Methodology

Collaborative Process Model

The collaborative process used to develop the Community Health Assessment (CHA) and Community Health Improvement/Service Plan (CHISP) is the Take Action Cycle, a model developed by **County Health Rankings and Roadmaps** (58), a collaboration of the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.

Take Action Cycle



The **Take Action Cycle** emphasizes how to create a healthier community (see diagram), wrapped with necessary elements of working together and communication. Each **Take Action Cycle** step includes key steps to undertake in an intentional process of community engagement in examining health issues, analyzing the social determinants of health contributing to health issues and identifying community assets that can be mobilized to address health needs.

Steps 1 - 2 are demonstrated in the CHA.

Steps 3 – 5 are demonstrated in the CHISP.

Step 1: Assess Needs and Resources

Framework for Conducting the Assessment

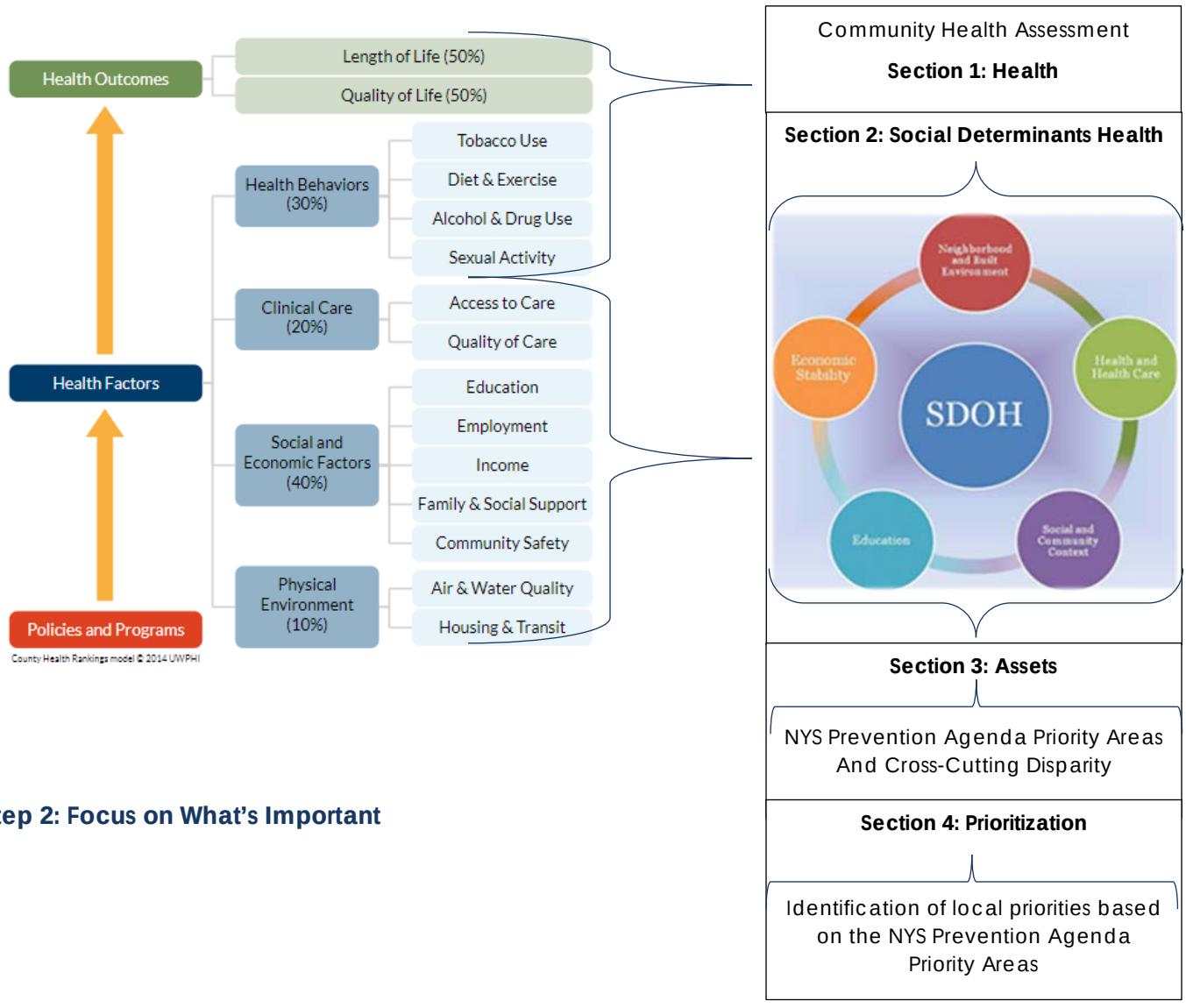
The Framework for conducting the assessment follows the **NYSDOH Prevention Agenda** (48) and the following two models it references:

- **County Health Rankings and Roadmaps Model** (58) and the
- **Healthy People Social Determinants of Health** (27).

The County Health Rankings and Roadmaps Model (58) emphasizes the many factors that influence health outcomes. Healthy People Social Determinants of Health Domains (27) reveal how factors of economic stability, education, health care access, neighborhood and the environment and social and community context impact health behaviors and outcomes. Exploration of these domains make evident the need to engage the broader (beyond health partners) community in working collaboratively across domains to address the unique needs of our communities and residents.

The diagram below depicts how this CHA integrates these three models as a single Framework.

Step 1: Assess Needs and Resources



Step 2: Focus on What's Important

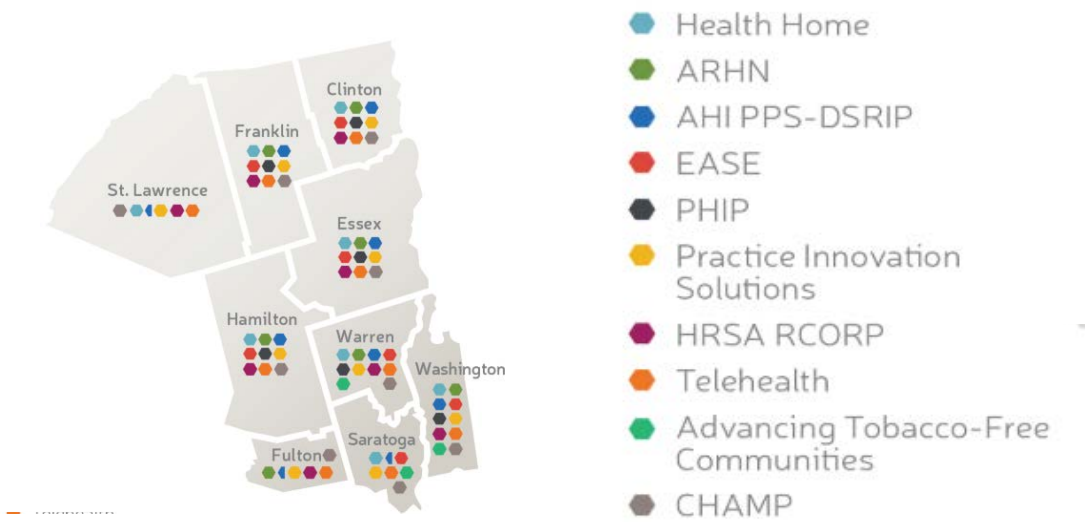
Regional Collaboration

Regional collaboration is facilitated by Adirondack Health Institute (AHI). AHI is an independent, non-profit organization categorized as an Article 28 agency under New York State Department of Health (NYSDOH) Regulations. AHI operates as a regional population health improvement network. (3)

AHI supports health care systems, practices, medical and healthcare providers, local health departments and community based organizations in transforming health care and improving population health through multiple programs. They are:

- Health Home Care Management
- Adirondack Rural Health Network (ARHN)
- AHI PPS (Performing Provider System): Delivery System Reform Incentive Payment (DSRIP) Program
- Enrollment Assistance Services and Education (EASE)
- Population Health Improvement Program (PHIP)
- Practice Innovation Solutions
- HRSA Rural Communities Opioid Response Program (HRSA RCORP)
- Telehealth/Telemedicine
- Advancing Tobacco-Free Communities
- Community Health Access to Addiction and Mental Healthcare Project (CHAMP). (3)

The figure below depicts which program are conducted throughout the AHI region.
Essex County is included in 9 of these programs. (3)

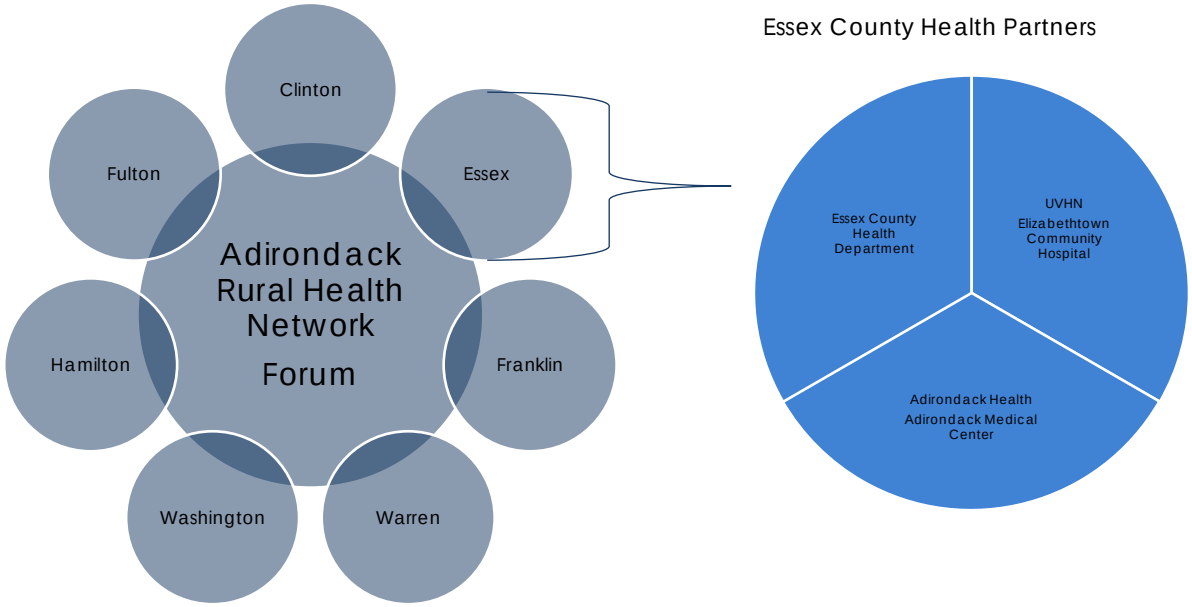


One of these programs, Adirondack Rural Health Network (ARHN), facilitates a Forum to assess regional health needs and develop collaborative responses to priority health issues. It does so through a seven-county multi-stakeholder coalition including Clinton, Essex, Franklin, Hamilton, Fulton, Warren & Washington counties of NY. (3)

The ARHN Forum is conducted through quarterly meetings to:

- Coordinate data collection
- Conduct a regional stakeholder survey
- Inform analysis & prioritization methods
- Determine regional priorities and initiatives

As displayed below, local partners from each of these counties contribute to the regional Forum. Representing Essex County are ***Essex County Health Partners***.



Regional Data Gathering and Analyzing

Intentional data gathering occurred in 2018 and 2019 through guidance of the ARHN partner forum; quarterly meetings. It was guided by a Data Sub-Committee that strategized on recommendations for quantitative and qualitative data needs assessment. The ARHN Ad Hoc Data Subcommittee included participation by ***Essex County Health Partners*** members.

There are three (3) components [and resulting documentation] of the regional data gathering and analysis:

- ARHN Stakeholder Survey Report (Appendix 1);
- ARHN Essex County Health Indicator Data Sheets (Appendix 2);
- ARHN Community Profile Data Sheets (Appendix 3).

ARHN Stakeholder Survey

The first component of regional data collection was qualitative input from stakeholders. The data sub-committee met seven (7) times in 2018 and proposed a survey that was approved at the December 2018 quarterly meeting of the regional forum to be used early in 2019.

The purpose of the survey was to gain valuable insight from key informants into factors impacting the health and well-being of the people their organization/agency serves with NYSDOH Prevention Agenda priorities. This survey also included asset information by asking about resources the respondents could provide to help address community needs. The target audience was local stakeholders as provided by ARHN members including ***Essex County Health Partners***. The survey was launched in January of 2019 using the electronic Survey Monkey platform; a paper version was not available.

Essex County Health Partners used internal contact lists based on existing committees, coalitions, networks, partnerships and contacts to identify the local target audience. The target audience was 170 key informants from a wide cross section of 18 different community based organization types. There were 129 responses from Essex County stakeholders.

Data from this regionally-launched survey was analyzed by ARHN staff who also provided a report to forum partners in April 2019.

ARHN Health Indicator Data Sheets

The second component of regional data collection was quantitative collection of data by ARHN and provided to its regional members in the format of the document identified as ARHN Essex County Health Indicator Data Sheets. These sheets are a compilation and analysis of hundreds of data indicators from a variety of sources.

These sheets were organized across ten tabs: *Mortality; Injuries, Violence and Occupational Health; Built Environment and Water; Obesity; Smoke Exposure; Chronic Disease; Maternal and Infant Health; HIV, STD, Immunization and Infections Diseases; Substance Abuse and Mental Health;* and *Other.*

Each indicator includes a link to the data source and columns for Essex County, the ARHN region, Upstate New York, New York State and the NYSDOH Prevention Agenda Benchmark (as available). An analysis of indicators is included and based on a comparison of the Essex County data to the NYSDOH Prevention Agenda Benchmark or Upstate NY (all counties in NYS excluding the 5 boroughs of New York City) if there was not an associated Benchmark.

The comparison is displayed as follows:

- Green: meets/exceeds/is better than the comparison
- Red: doesn't meet/falls below/ worse than the comparison.
- Yellow: Less than 10 incidence making the data indicator statistically unstable/unreliable

To provide context for the distance of the given indicator data [rate or percent], from the comparison data (Benchmark or Upstate NY) a quartile ranking was used as follows:

- Quartile 1: within 24.9% of comparison
- Quartile 2: between 25% and 49.9%
- Quartile 3: between 50% and 74.9%
- Quartile 4: 75% to 100% from the comparison

In other words, data indicators closest to the comparison are within Quartile 1; farthest in Quartile 4. A Quartile score is included and based on the percent of indicators that were worse than the comparison of total indicators.

Finally, these sheets include a severity score, the percentage of indicators that were either in quartile 3 or 4.

ARHN Community Profile Data Sheets

The third component of regional data collection was the quantitative collection of community profile data by the ARHN.

These sheets are a compilation of data from additional sources and are organized by these tabs: *Demographic Profile, Health System Profile, Education Profile, and Asset Limited Income Constrained Employed (ALICE) Profile.*

Local Collaboration

Primary partners/lead agencies engaged in the development of the CHA and CHISP identify as ***Essex County Health Partners*** and include:

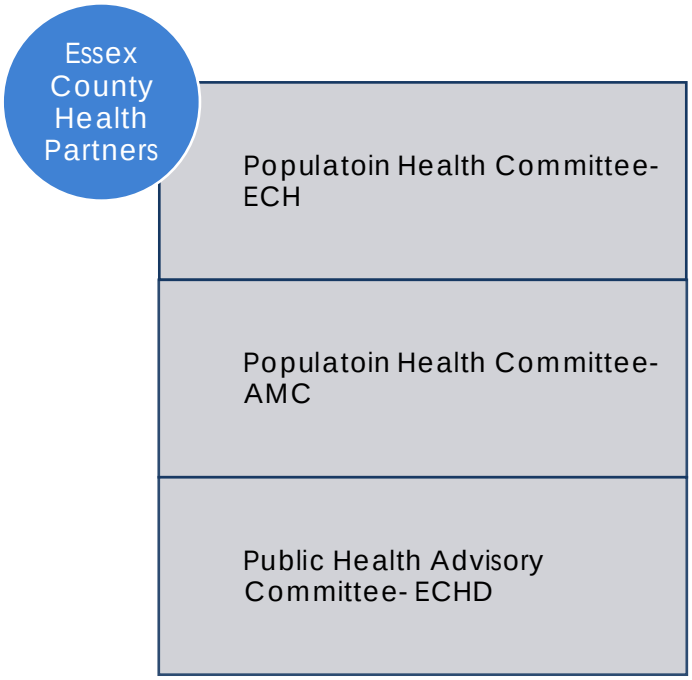
- Essex County Health Department (ECHD),
- University of Vermont Health Network-Elizabethtown Community Hospital (UVHN-ECH) and
- Adirondack Health-Adirondack Medical Center (AMC).

These partners participate in the ARHN regional forum quarterly and ad-hoc sub-committees described above.

ECHD, UVHN-ECH and AMC met more than a dozen times during 2019 to collaborate on the development of this assessment. Meetings were conducted in person, through the virtual Zoom meeting platform and phone calls. Partners also collaborated using email, meetings and sharing information using the internet based platform, Drop Box.

Essex County Health Partners lead three (3) key committees responsible for sharing and analyzing data related to population health, health challenges and community resources. These committees each meet quarterly (at a minimum), and more as necessary. They are:

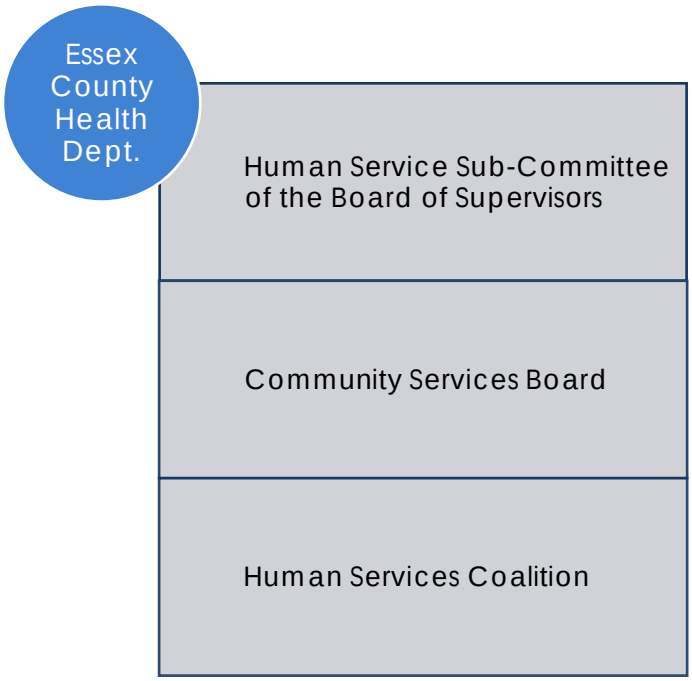
- Public Health Advisory Committee of the Essex County Health Department
- Population Health Committee of Adirondack Health
- Population Health Committee of UVHN-Elizabethtown Community Hospital



Additionally, Essex County Health Department led or participated in local community based committees, coalitions and workgroups that informed health needs assessment and improvement planning.

The three (3) multi-sector committees that are engaged with ongoing assessment and planning efforts are:

- Essex County Human Service Sub-Committee of the Board of Supervisors,
- Essex County Community Services Board facilitated by the Essex County Mental Health Department and the
- Human Services Coalition facilitated by the Adirondack Community Action Program.



Appendix 4 is a list of these six (6) committees including participating members, and the agency/organization they represent with the meeting dates for 2018-2019.

Local Data Gathering and Analyzing

Beyond participation in regional data collection efforts, intentional local data gathering and analyzing efforts were conducted during 2018-2019, led by ***Essex County Health Partners*** and through multiple committees and work groups as described previously in the Local Collaboration section.

Efforts to include new primary and secondary data, and qualitative and quantitative data, may be categorized into four initiatives described further below. These efforts helped ensure input from local organizations, stakeholder and community members and included gathering of additional new information about the social determinants of health [as they exist for Essex County].

There are three (3) components of the local data gathering and analysis resulting in stand-alone documents:

- Distributed Focus Group Analysis Report (Appendix 5);
- Community Survey Analysis Report (Appendix 6); and
- Stakeholder Survey Analysis Report (Appendix 7).

Distributed Focus Group Initiative

The first local component was called a Distributed Focus Group Initiative. The purpose was to ask a single broad question across multiple stakeholder groups: *If you could change one thing about your community to make it better what would it be?* From January-March 2019 Essex County Health Department staff asked the question and facilitated discussions at existing community coalitions/networks/committee stakeholder meetings; the target audience of the initiative.

Staff documented the names of groups, number of participants and responses. In total, 5 groups of stakeholders, facilitated by three different staff and including 49 stakeholders were surveyed. This process was trialed as a strategy to provide latitude in interpreting the question being asked, leading to a wide range of responses what were likely to tap into social determinants of health areas. Results were analyzed by Essex County Health Department staff and the results are included in Section 2 of the Community Health Assessment.

Community Survey Initiative

The second local component was a Community Survey. The purpose of the survey was to engage a wide variety of community members to collect their perspectives about community health including their definition of health, challenges within the community including health, social and environmental and challenges experienced by respondents and their families including social and access to healthcare. The target audience was Essex County residents ages 18 and older. The survey was designed at a 7th grade reading level and took approximately 10 minutes to complete. It was primarily launched on the electronic Survey Monkey platform though paper versions were also distributed. Efforts were made to reach a wide variety of residents including ages, genders and social connections. Three hundred and fifty four (354) residents participated in the survey. Results were analyzed by the Essex County Health Department staff and included throughout the Community Health Assessment

Stakeholder Survey Initiative

The third local component was further analysis of the ARHN Stakeholder Survey Report with a focus on just Essex County conducted by Essex County Health Department staff.

Local Data, Surveys and Reports Initiative

A final local component was the collection, review and analysis of local data by ***Essex County Health Partners*** including needs and contributing factors. This information included raw data, survey results, reports and plans from local agencies, programs and groups.

Examples of such information includes the:

- Adirondack Community Action Programs Community Assessment Report 2019;
- Area Agency on Aging/Essex County Office for the Aging County Plan for 2020-2024; and
- Essex County Local Service Plan 2020.

This assessment, more than any previously conducted local Community Health Assessment, provides an examination of factors that contribute to health challenges – otherwise described as Social Determinants of Health. Research to find this type of information yielded the collection, review and analysis of information from numerous new sources and is included in Section 2 of the Community Health Assessment. A complete list of Data Sources is included as Appendix 8.

Sharing Preliminary Information & Using Feedback

Preliminary data and reports were shared with stakeholders and the community at large to gather additional input and feedback before the completion of this assessment. This includes sharing, posting and presenting with requests and opportunities for feedback through these methods:

- Stakeholder Survey Report – emailed to Stakeholders that had been invited to participate in the survey
- Community Survey Report - posted on the Essex County Health Department Facebook page and website
- Preliminary Findings – posted on the Essex County Health Department Facebook page and website
- Preliminary Findings – presented to:
    - Public Health Advisory Committee (PHAC) of Essex County Health Department
    - Essex County Board of Supervisors (BOS)
    - University of Vermont Health Network-Elizabethtown Community Hospital (UVHN-ECH) Internal Planning Team
    - Adirondack Health-Adirondack Medical Center (AH-AMC) Population Health Committee

These opportunities yielded additional information including but not limited to:

- Prioritization input;
- Themes to include in the final report:
    - Alzheimer's Disease, elder care and care-giver care;
    - Climate Change;
    - Travel barriers, telehealth and telemedicine;
    - Food access and physical fitness; and
- Request for more overlaying of data.

This information was captured, considered and integrated as possible in the final assessment report.

Step 2: Focus on What's Important (Prioritization)

Numerous steps were taken to inform the prioritization of health needs by ***Essex County Health Partners***:

1. Analyzing 3 Regional Data components [as described in Regional Data Gathering and Analysis];

2. Analyzing 4 Local Data components [as described in Local Data Gathering and Analysis];

3. Using a prioritization matrix with internal planning groups of:

- Essex County Health Department
- University of Vermont Health Network-Elizabethtown Community Hospital
- Adirondack Health-Adirondack Medical Center

Internal planning groups of the ***Essex County Health Partners*** included:

- Essex County Health Department team was comprised of the Director of Public Health, Director of Preventive Services, Community Health Assessment and Planning Coordinator and Senior Health Educator. This group met over a dozen times during 2019.
- UVHN-ECH Internal Planning Team was comprised of the Chief Nursing Officer/Vice President; Medical Director, Director of Quality, Primary Care Quality Support Specialist and Director of Communications and met once during 2019.
- Adirondack Health Population Health Steering Committee was comprised of the Chief Medical Officer, Chief Nursing Officer, Chief Financial Officer, Chief Operating Officer, and Chief Financial Officer and representation from Program Managers to Care Coordinators from both in-Patient and Outpatient programs and services met eight (8) times during the 2019 year.

The prioritization matrix (Appendix 9) was a locally-modified version of the Hanlon Method[1] that included criteria categories of need and feasibility. The matrix was guided by asking questions regarding the scope and severity (need) of health issue and the perceived ability to impact and community readiness (feasibility) regarding addressing those health issues.

Health issues were categorized and scored following the five (5) NYSDOH Prevention Agenda[2] areas:

- Prevent Chronic Disease
- Promote a Healthy & Safe Environment
- Promote Healthy Women, Infants & Children
- Promote Well-Being and Prevent Mental Health & Substance Use Disorders
- Prevent Communicable Diseases

[1] https://www.naccho.org/uploads/downloadable-resources/Gudie-to-Prioritization-Techniques.pdf
[2] https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/index.htm

Internal planning groups of ***Essex County Health Partners*** identified priorities as:

- Prevent Chronic Disease (3 of 3 groups)
- Promote Healthy Women, Infants & Children (2 of 3 groups)
- Promote Well-Being and Prevent Mental Health & Substance Use Disorders (3 of 3 groups)

4. Sharing preliminary findings and requesting prioritization input upon review of these findings from:

- Essex County Health Department Public Health Advisory Committee (PHAC)
- Essex County Board of Supervisors (BOS)
- Essex County Community Members

5. Drawing a conclusion to address 3 priorities in the Community Health Improvement/Service Plan:

- Prevent Chronic Disease
- Promote Healthy Women, Infants & Children
- Promote Well-Being and Prevent Mental Health & Substance Use Disorders

Identification of Disparities

Essex County Health Partners identified disparities during the data analysis process.

Within Section 1: Health, disparities were identified within each priority area specific to indicators including:

- Age
- Gender
- Geography/Communities within the county
- Socio-economics as Medicaid/Non-Medicaid

Disparities were identified within the Community Health Assessment report for specific health indicators in Section 1: Health, and within Section 2: Social determinants of Health within sub-areas of each domain.

Within Section 2: Social Determinants of Health, Access to Healthcare was identified as a cross-cutting disparity for Essex County residents and include barriers of Geography, Transportation and Provider Shortages. Additionally, the changing healthcare environment is addressed in the Community Health Assessment as an evolving issue. Themes identified in this section of the report underscore how the system continues to evolve to improve healthcare experiences of residents and address this cross-cutting disparity.

Asset Identification

Essex County Health Partners also considered local assets that may be mobilized to address community health. Existing resources data was gathered and assembled into a matrix including the locally identified priority areas of the NYSDOH Prevention Agenda Priority Areas and the locally identified cross-cutting Social Determinant of Health: Access to Health Care.

Categories include Healthcare System; Coalitions and Committees; County Government Departments; Community Based Organizations; Media, Law Enforcement, Education Systems, Religious Groups, Local Programs and Grants, and New York State Health Department and Associations.

Section 3 of the Community Health Assessment is the Asset Matrix.

Essex County Health Partners recognize the benefit of additional asset mapping including broader considerations such as programs and policies directly or indirectly influencing health and as related to additional Social Determinants of Health.

This activity informed prioritization and is an essential piece of the Take Action Cycle as work progresses into identifying effective programs and policies.

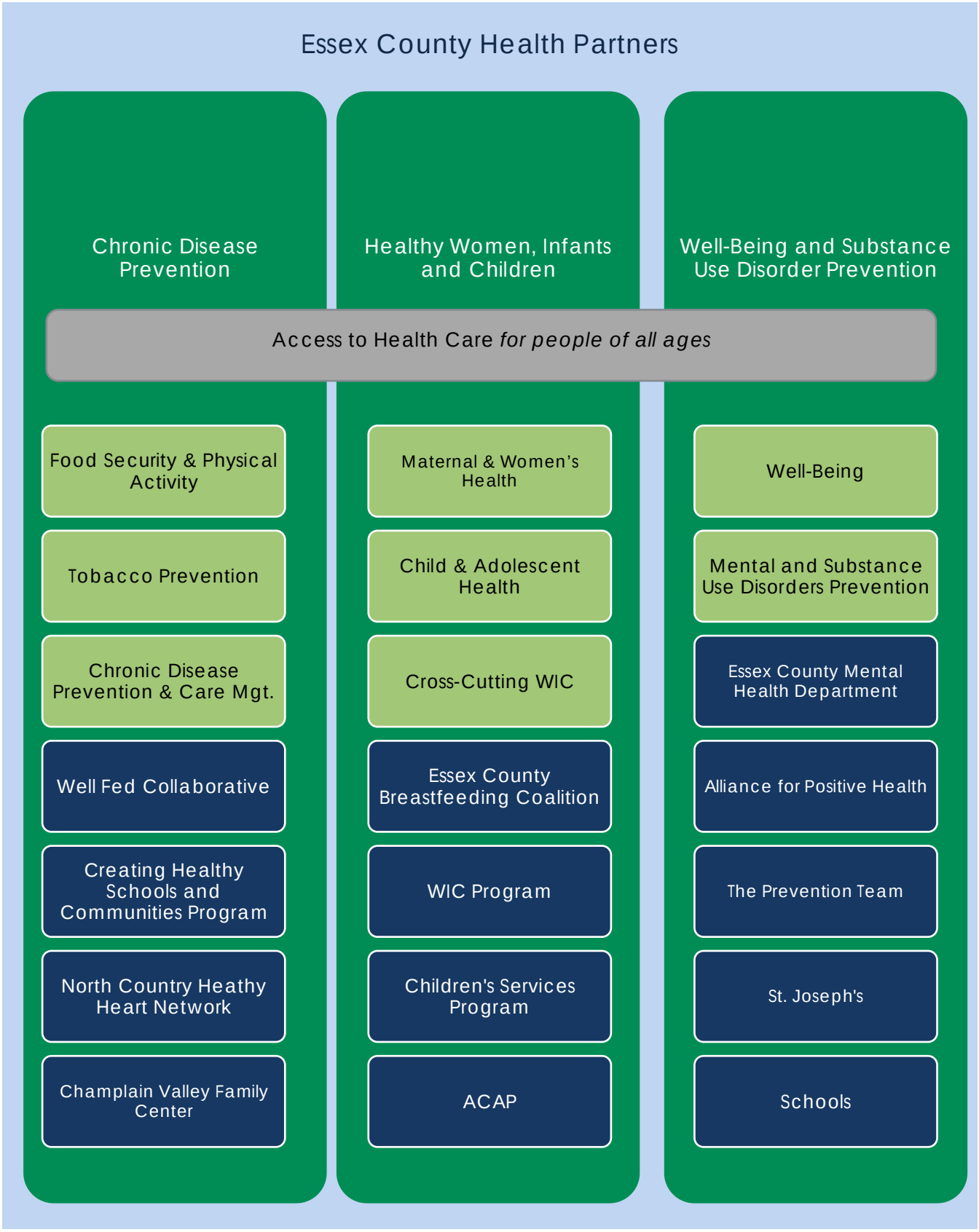
Step 3: Choosing Effective Policies & Programs

Planning was informed through long-standing relationships between ECHD, hospitals, community based organizations and stakeholders. Collaboration and communication occurs directly between and among community based partners and stakeholders. Specific to the Improvement/Service Plan Part of this report, work was convened by priority area as depicted in the visual aid on the following page.

Workgroups for each priority area were convened and considered:

- Data leading to these priority areas
- Disparities experienced by sub-categories of populations within these priority areas
- Social Determinants of Health contributing to priority outcomes and disparities
- Evidenced-based interventions as directed by NYSDOH
- Assets that may be mobilized to address health needs
- Lead organizations for specific interventions and community based partners essential to intervention success

The graphic below depicts Essex County Health Partners (in light blue) overseeing the identification of three (3) health priorities (in green) and focus areas (in light green) with the cross-cutting disparity of Access to Healthcare (in grey). It also demonstrates the engagement of community based organizations, programs and partners (in dark blue) in the development of interventions.


Essex County Health Partners
Chronic Disease Prevention
Healthy Women, Infants and Children
Well-Being and Substance Use Disorder Prevention
Access to Health Care for people of all ages
Food Security & Physical Activity
Tobacco Prevention
Chronic Disease Prevention & Care Mgt.
Well Fed Collaborative
Creating Healthy Schools and Communities Program
North Country Heathy Heart Network
Champlain Valley Family Center
Maternal & Women's Health
Child & Adolescent Health
Cross-Cutting WIC
Essex County Breastfeeding Coalition
WIC Program
Children's Services Program
ACAP
Well-Being
Mental and Substance Use Disorders Prevention
Essex County Mental Health Department
Alliance for Positive Health
The Prevention Team
St. Joseph's
Schools

Step 4: Acting on What's Important

The Lead Partner for these workgroup activities established work plans for each of the three priority areas. A summary of these interventions is described in Part III: Community Health Improvement/Service Plan.

Interventions in the CHISP include an array of strategies to improve population health including:

- Coalitions and other community planning efforts;
- Policy, systems and environmental changes;
- Public health marketing and campaigns;
- Outreach, education, training and technical assistance;
- Delivery of early detection and guideline-concordant health care; and
- Application of new technologies in healthcare and improved care coordination.

A detailed description of these interventions (Appendix 10; CHISP Work Plan) includes:

NYSDOH Prevention Agenda Identified:

- Priority
- Focus Area
- Goal

Locally Identified:

- Objectives
- Disparities
- Interventions
- Family of Measure for Evaluation
- 3 Years of Planned Activities
- Partners
- Partner Roles and Resources.

Examples of Process measures included:

- Number of trainings provided
- Number of media campaigns and engagement
- Number of policies revised and updated
- Number of health practices screening and referring
- Number of smoke-free housing unit, parks and playgrounds
- Implementation of updated guidance related to priority areas
- Number of programs offered and residents served

Essex County Health Partners will share the CHISP with the ARHN Forum to facilitate regional planning and identification of additional regionally-based activities.

Step 5: Evaluating Actions

Essex County Health Partners and the community based organization partners engaged in the planning of the CHISP have pledged on-going commitment to the health and well-being of Essex County residents.

Minimally, ***Essex County Health Partners*** will meet quarterly to:

- assess progress on activities,
- identify barriers to the implementation of activities, and
- develop strategies to overcome barriers and/or determine how activities may be adjusted for success.

The Lead Partner for each activity will document activities through quarterly work plan updates.

A representative of ***Essex County Health Partners*** will submit this update to NYSDOH quarterly.

The Take Action Cycle was the foundational basis for conducting the Community Health [Needs] Assessment and for developing the Community Health Improvement/Service Plan. The following Part includes these two major components, as well as an analysis of various other supporting data, documents, and information that helped to shape conclusions and direction.

PART II: COMMUNITY HEALTH ASSESSMENT 2019

Executive Summary

PART I: Introduction

PART II: Community Health Assessment 2019

PART III: Community Health Improvement/Service Plan 2019-2021

PART IV: Dissemination Plan

Part V: Appendices

Purpose

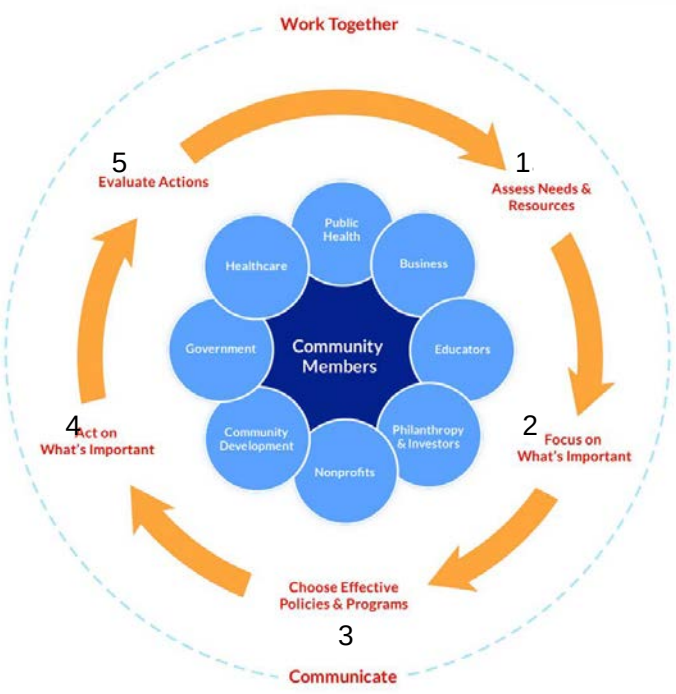
The purpose of this Community Health Assessment is to demonstrate an ongoing understanding of the significant health needs of Essex County residents.

Needs were identified through a comprehensive analysis of multiple-source data, community perceptions, and a solid historical knowledge of the region, cultivated after years of service to individuals and families in the county by the service agencies referenced in this report.

Collaborative Process Model

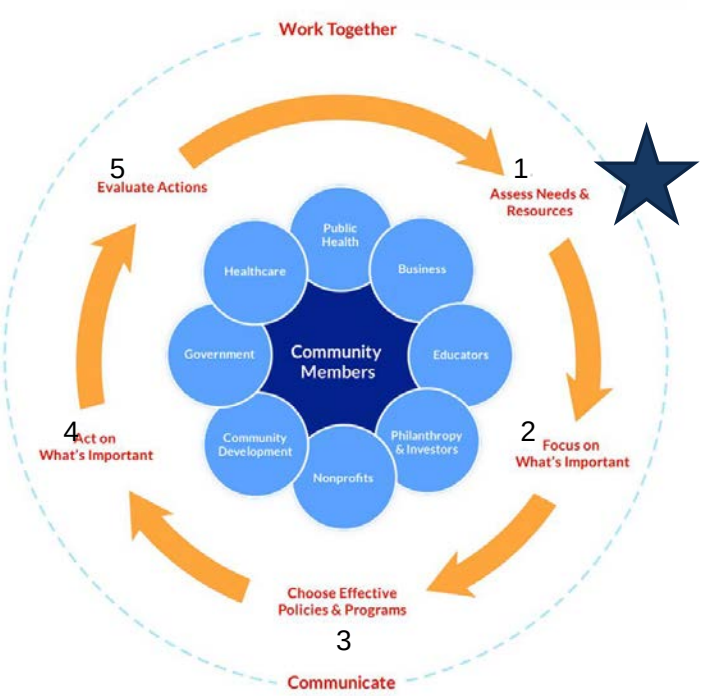
As described in PART I: Introduction, the collaborative process used to develop the Community Health Assessment (CHA) and Community Health Improvement/Service Plan (CHISP) is the **Take Action Cycle** (58). The **Take Action Cycle** (see diagram below) emphasizes how to create a healthier community, wrapped with necessary elements of working together and communication.

Take Action Cycle



Take Action Cycle Steps 1-2 are included in this Part II: Community Health Assessment of the full report.

Step 1: Assess Needs and Resources



Framework for Conducting the Assessment

The Framework for conducting the assessment follows the **NYSDOH Prevention Agenda (PA)** (48) and the following two models it references:

- **County Health Rankings and Roadmaps Model (CHR)** (58) and the
- **Healthy People Social Determinants of Health (HP)** (27).

The County Health Rankings and Roadmaps Model emphasizes the many factors that influence health outcomes. Healthy People Social Determinants of Health Domains[3] reveal how factors of economic stability, education, health care access, neighborhood and the environment and social and community context impact health behaviors and outcomes. Exploration of these domains make evident the need to engage the broader (beyond health partners) community in working collaboratively across domains to address the unique needs of our communities and residents.

The diagram below depicts how this CHA integrates these three models as a single Framework.

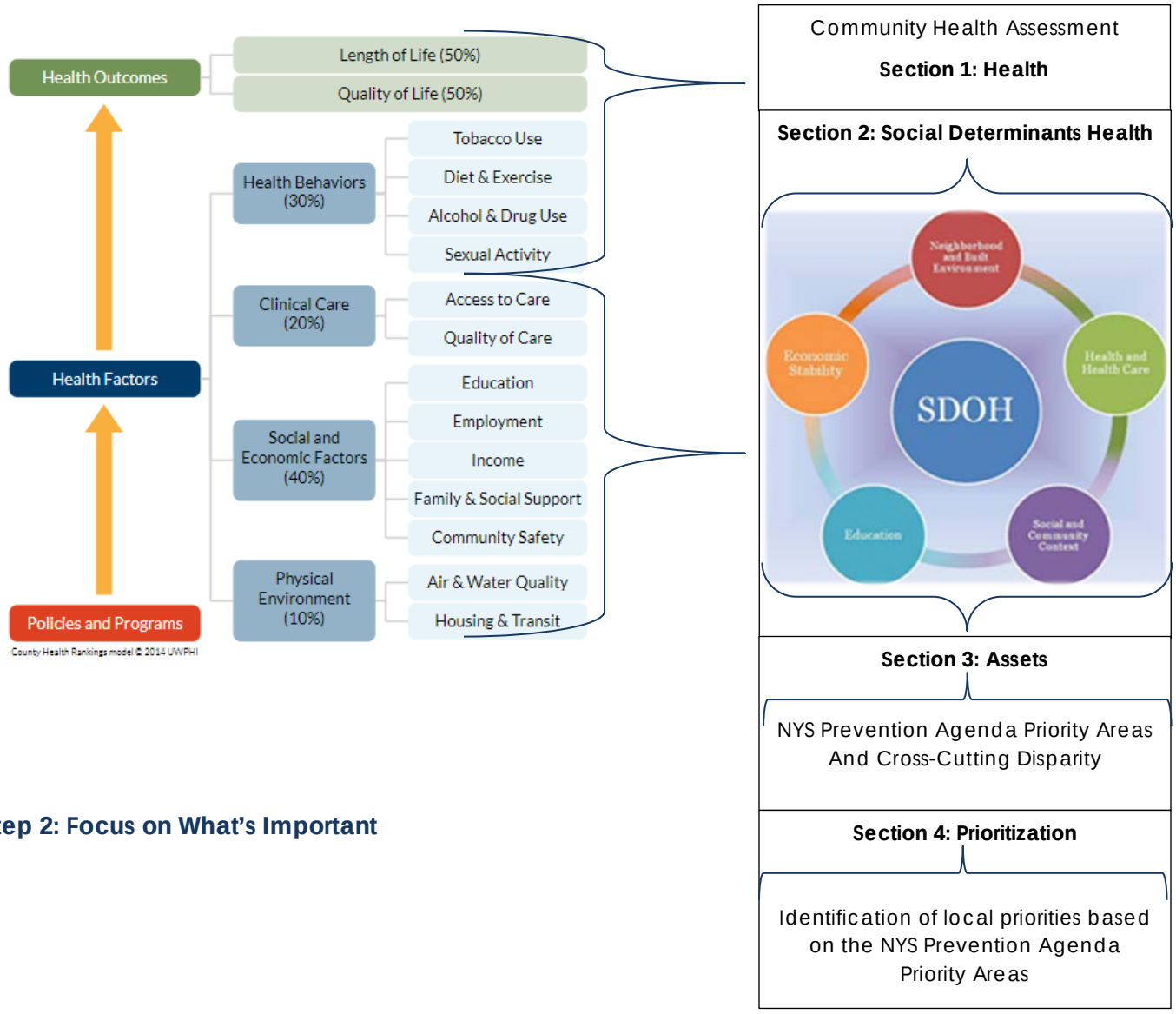
Step 1: Assess Needs and Resources

Section 1 includes CHR Health Outcomes and Behaviors;
Section 2 includes CHR Health Factors following HP domains;
Section 3 follows the PA priority areas; and

Step 2: Focus on What's Important

Section 4 follows the PA

Step 1: Assess Needs and Resources



Step 2: Focus on What's Important

Reading This Report

Moving through this report readers will find data expressed as percent, rate or ratio and analysis in the form of text, tables, charts and visualizations. Following are explanations of how data is expressed and how to interpret elements of data analysis that appear in the report.

References to Data Sources

References to data sources used in this report are expressed as a number in parentheses that links back to the Source List (Appendix 8) immediately following a point of reference, within text, tables, charts or figures. For the purpose of this report, sources are listed with just two identifiers; a number that refers to a source. The source may be listed as an agency, report, item, etc. More detailed information is available upon request. For example:
(1) means Adirondack Community Action Program Community Assessment Report 2019.

WHY IT MATTERS This section identifies why the health issue or social determinant of health matters for all people, everywhere. It identifies the relevance of the specific topic to overall health and quality of life.

WHY IT'S A PRIORITY IN ESSEX COUNTY is found in the Priority Health Issues section and includes supporting data that lead to this issue being identified as a priority health need in Essex County.

IN ESSEX COUNTY is found in the Social Determinants of Health section and includes data and information specific for the topic, specific to Essex County.

Understanding Percent Expressions

A Percent is expressed as a portion of 100%.
For example, if 500 people were surveyed and 125 answered a certain way (yes), than 25% of the people said yes to this question.

Understanding Rate Expressions

Rates are expressed as per (/) 1,000 (1K); 10,0000 (10K); or 100,000 (100K).
For example, if there are 25 lung cancer deaths in one year in a population of 30,000, then the mortality rate for that population is 83 per 100,000 (83/100K).

Understanding Ratio Expressions

Ratios are expressed as a discrepancy from 1:1.
For example, a premature death ratio of Blacks to White non-Hispanics of 1:1 would mean there is no difference/discrepancy in premature deaths for these sub-populations of people.

Continuing the example, if pre-mature deaths of Blacks is 28% and that of White non-Hispanics is 15%, then the ratio is calculated as Blacks (28%) divided by White non-Hispanics (15%) resulting in a ratio expressed as 1.87. This means there is a discrepancy in premature deaths for Blacks as compared to White non-Hispanics.
Ratios are also expressed for patients to providers. For example, there are 1,234 patients for every 1 provider which appears as 1,234:1.

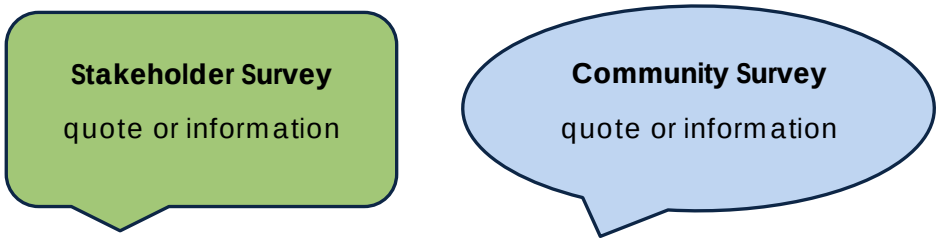
Other Notations and Symbols

NA means the data was not available or like data was not available for inclusion.

***** means the percent, rate or ratio is unreliable due to small incidence or number of occurrences. The number of occurrences may be under 10, 20 or 30 and is specific to the indicator.

N= means the number of people who answered a question in the survey
For example N=345 means 345 people answered the question in the survey.

Word Bubbles mean



Essex County Trend

Percent, rate or ratio of current Essex County data compared to previous Essex County data.
Previous = indicator data as available upon 2016 assessment
Current = indicator data as available upon 2019 assessment
The year or year range varies for each indicator. Specifics are available by going to the data source or upon request. This display simplifies the data view in this report.

Trends are identified as:

▲ ▼	On Track/Improving	EXAMPLES: % Screening increased & this is good Cancer case rate decreased & this is good
■	Stable/No Significant Change	EXAMPLE: Early prenatal enrollment was 51.2; now 51.1; stable
▲ ▼	Off Track/Worsening	EXAMPLES: Cancer case rate increased & this is not good % Screening decreased & this is not good

Essex County Compared to

Whenever available, the New York State Department of Health Prevention Agenda benchmark (NYS Benchmark) was used as a comparison point. If not available for the indicator, than a comparison of Upstate New York (NYS except NYC), NYS or other comparison data set is used.

Comparisons are identified as:

- Meets/performs better than the comparison
  EXAMPLE: 80% screening in Essex County is better than the NYS Benchmark of 70%

- Performing at the comparison
  EXAMPLE: % screening in Essex is 79.8 which is very close to the NYS Benchmark of 80.0

- Doesn't meet the comparison
  EXAMPLE: 70% screening in Essex County does not reach the NYS Benchmark of 80%

Quartile Explanation

To provide context for the distance of the given indicator data from the comparison data, a quartile ranking was used as follows:

- Quartile 1: within 24.9% of comparison
- Quartile 2: between 25% and 49.9% of the comparison
- Quartile 3: between 50% and 74.9% of the comparison
- Quartile 4: 75% to 100% from the comparison

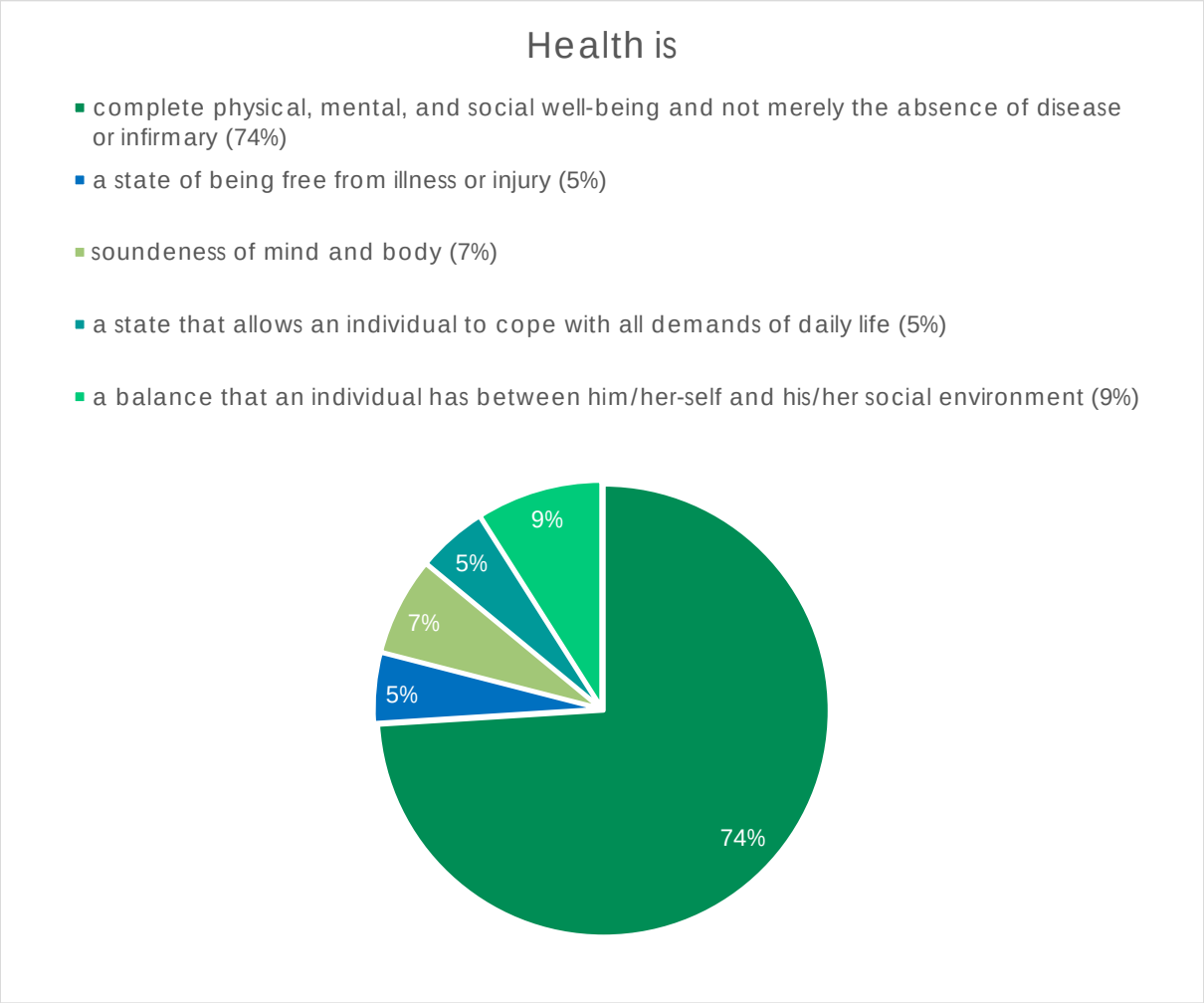
In other words, data indicators closest to the comparison are within Quartile 1; farthest in Quartile 4. For example, an indicator that is in the 4th quartile from the NYS Benchmark means it is significantly away from the benchmark.

SECTION 1: HEATH

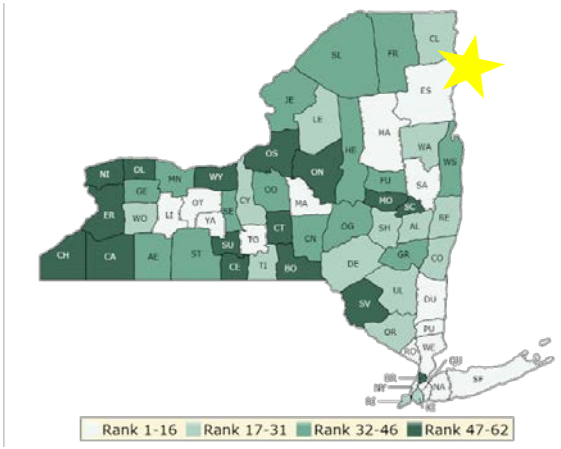
The first section of this Part of the report provides a brief synopsis of health in Essex County, establishing the context within which decisions were made about the selection of the three (3) health priorities that are the focus of Community Health Improvement/Service Plan.

Community Definition of Health

The Community Survey asked residents to select one definition, of 5 offered, that best describes "health". Health was largely agreed upon as a state of complete well-being and not merely the absence of disease. Results of responses to this question are displayed in the chart below. This definition was important to understanding community perspective and helped inform the scope of this CHA.



Population Health Status Overview



County Health Rankings (58)

Essex County ranks:

10th in Health Outcomes

13th in Contributing Factors

Standardized measures based on numerous factors show Essex County residents enjoy better health outcomes than peer residents across NY.

Health Outcomes

INDICATOR	Essex County Trend	Essex County Previous	Essex County Current	Essex County compared to NYS Benchmark	NYS Bench mark
Premature deaths (before 65 years)% (48)	▼	23.7	19.1	●	21.8
Preventable hospitalizations/10K (48)	▲	88.9	109	●	122
Babies with low birth weight % (26)	▼	7.3	5.7	●	7.9
Adults reporting poor mental health % (26)	▲	11.3	14.4	●	10.1
Adults reporting poor physical health % (40)	▲	12.0	15.4	●	12.0*

*This indicator uses Update NY as a comparison; NYS Benchmark unavailable.

Contributing Factors

INDICATOR	Essex County Trend	Essex County Previous	Essex County Current	Essex County compared to NYS Benchmark	NYS Bench mark
BEHAVIORS (5)					
Obesity %	■	32.2	32.2	●	23.2
Smokers %	■	16.6	16.8	●	12.3
Binge drinking in the last month %	▲	21.9	24.7	●	18.4
Births (ages 15-19) rate /1K females	▲	19.4	20.5	●	13.2*
CLINICAL CARE					
Uninsured % (5)	▼	10.2	6	●	7
Primary Care Providers (58)		NA	2,540:1	●	1,200:1
Dentist Rate (58)		NA	3,160:1	●	1,230:1
Mental Health Providers (58)		NA	720:1	●	370:1
SOCIO-ECONOMIC FACTORS (5)					
Unemployment %	▼	6.9	3.2	●	4.3
People in Poverty %	▼	11.4	8.9	●	15.1
Less than High School Education %	▼	12.0	9.1	●	13.9
Some College %	▼	20.7	20.2	●	15.9

*NYS Benchmark for births 15-17 is unstable, given incidence is less than 10; thus Upstate NYS and age range of 15-19 are used instead of NYS Benchmark.

Priority Health Issues

Priority Health Issue: Chronic Disease

Extensive review of the data (health indicators, social determinants of health, survey results, etc.), coupled with a collaborative prioritization process, led to the selection of three (3) New York State Prevention Agenda priority areas – Prevent Chronic Disease; Promote Well Being and Prevent Mental Health & Substance Use Disorders; and Promote Healthy Women, Infants & Children.

Chronic Disease is the first issue examined in-depth in this report. Sub-categories of obesity; diabetes, lung disease, tobacco, and nicotine; and vaping were singled out as major factors contributing to the burden of chronic disease in Essex County. These subsections frame each factor in terms of "Why it Matters" and "Why it's a Priority", providing the universal health consequences of each factor, as well as the health impacts that are distinctly experienced by Essex County.

Obesity

WHY IT MATTERS (10)

Obesity increases risk of many other physical & mental health conditions & death:

- Diabetes
- High blood pressure, cholesterol & triglycerides
- Heart disease
- Stroke
- Gall Bladder disease
- Sleep Apnea & sleeping problems
- Pain & Osteoarthritis
- Some cancers
- Depression, anxiety & other mental health disorders

Obesity itself can lead to premature death.

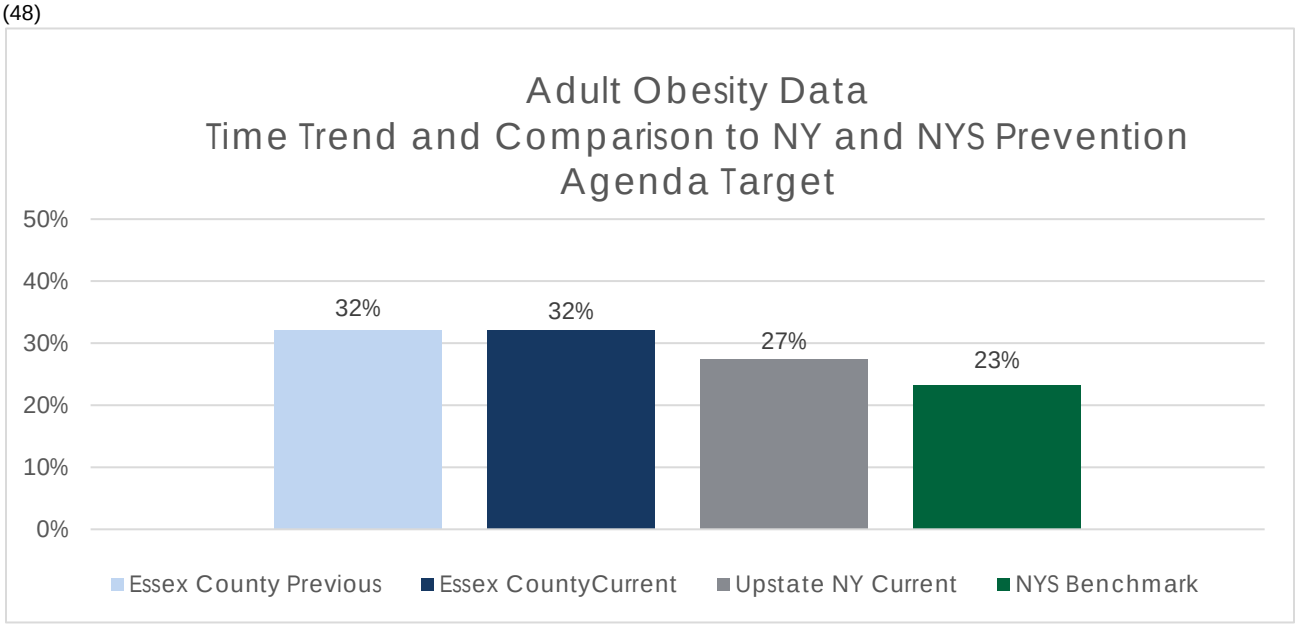
For children there are similar consequences:

- Risk of type II Diabetes, high blood pressure, high cholesterol & heart disease
- Risk of fatty liver disease, joint pain, asthma & breathing problems
- Social problems including low self-esteem, anxiety & depression
- More likely to become obese adults & suffer more severe health outcomes

WHY IT'S A PRIORITY IN ESSEX COUNTY

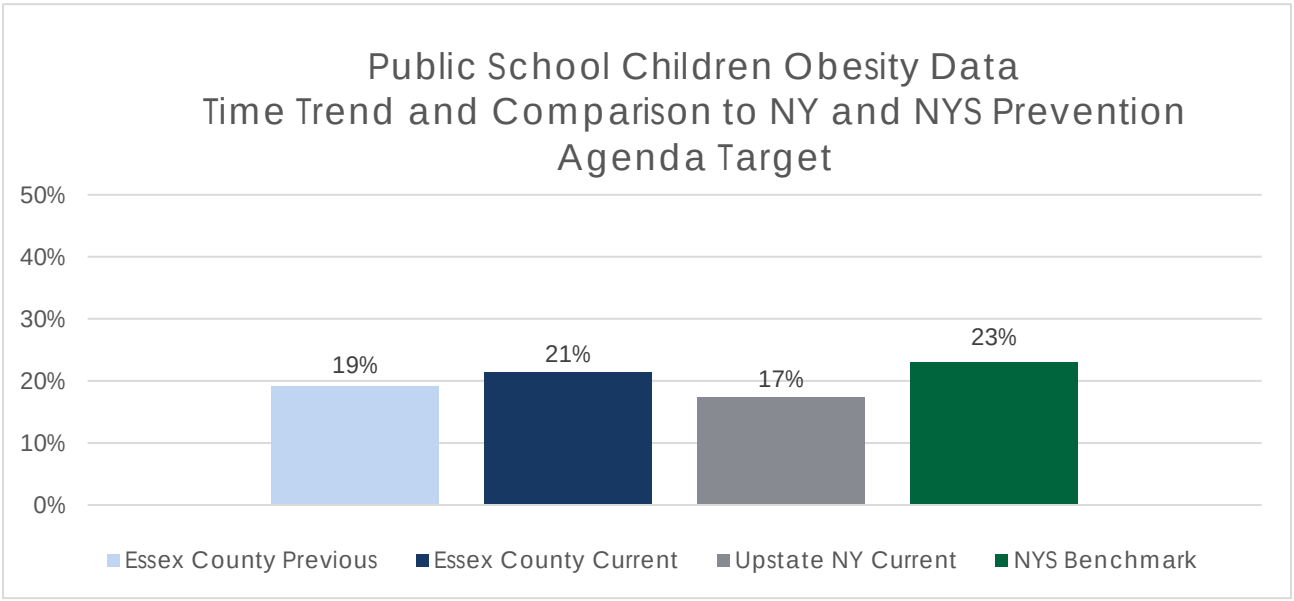
Adult obesity remains stable from the previous assessment to this current assessment; 32%. The current percent of adults with obesity is 5 percentage points higher than Upstate NY; 27%, and 9 percentage points away from the NYS Benchmark; 23%. See the chart below. (48)

(48)



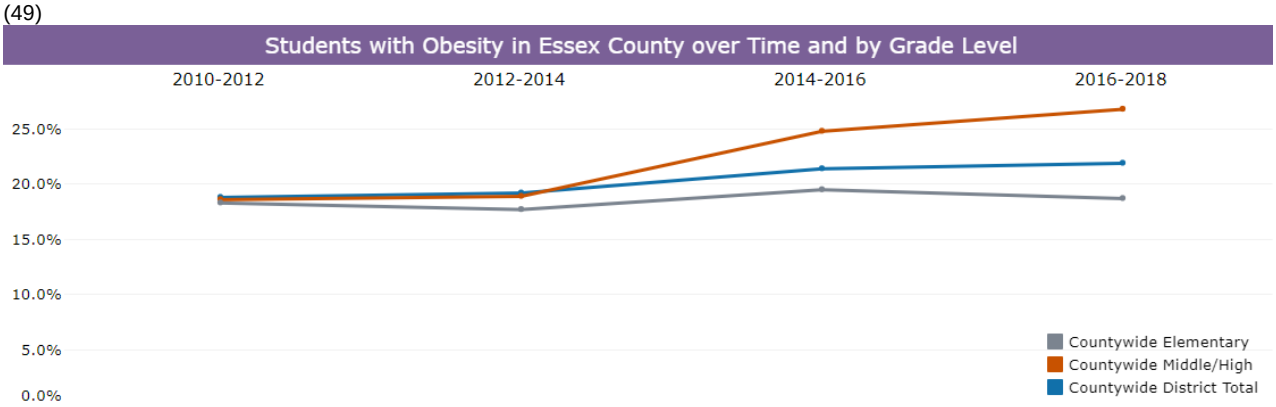
Analysis of available data for students in Elementary and Middle/High levels in Essex County demonstrates a trend of increase from the previous to current assessments as seen below. (48)

(48)



As displayed below in the chart, there are consistently more students with obesity in the Middle/High age group than the Elementary (49). High needs districts, as identified by NYSDOH applying five (5) elements of risk indicators included Elizabethtown-Lewis Central School District (CSD); Moriah CSD and Ticonderoga CSD (43).

(49)



Diabetes

WHY IT MATTERS (10)

Diabetes is a leading cause of disability & death.

It causes other health conditions including

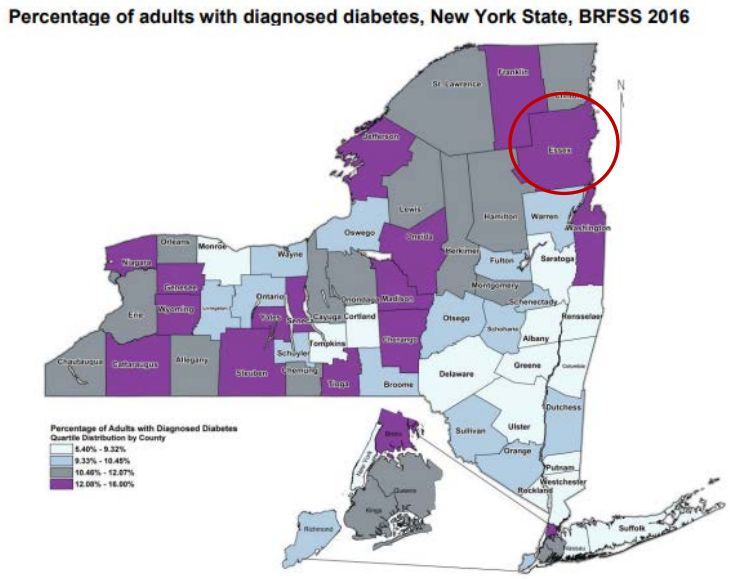
- Heart disease
- Stroke
- Kidney disease
- Vision problems
- Amputations due to circulatory problems

People with Diabetes use more healthcare & miss more work.

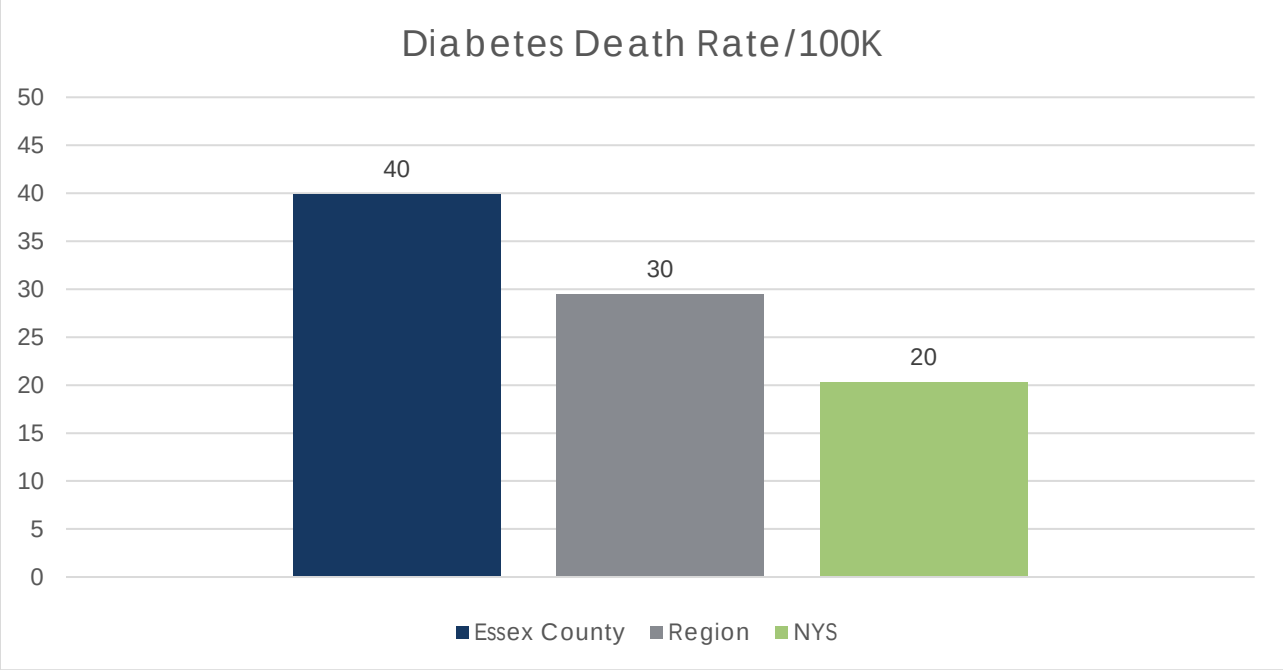
Diabetes is largely preventable.

WHY IT'S A PRIORITY IN ESSEX COUNTY

Fourteen percent (14.2%) of the adult population has Diabetes. This is higher than NYS (10.5%) and the 4th highest percent in NYS (45).

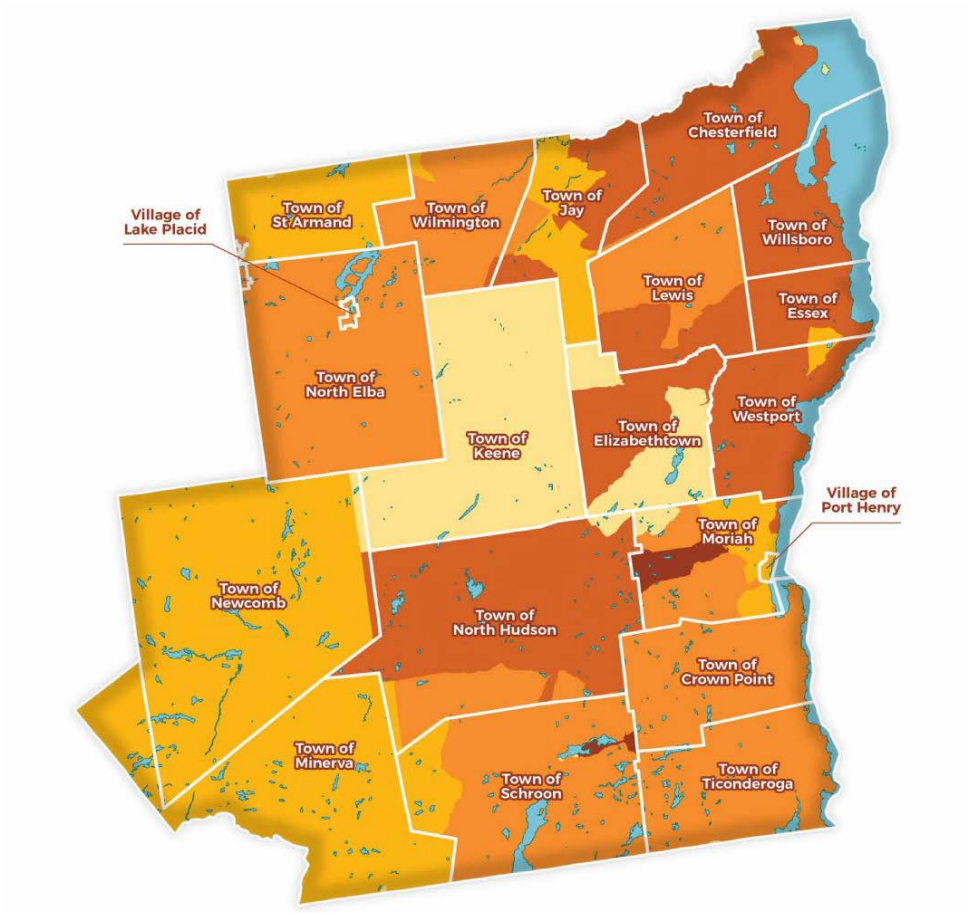


The death rate due to Diabetes in Essex County (40/100K) is higher than the Region (30/100K) and double that of NYS (20/100K) – see the visual aid (chart) below (5).



The map below depicts hospital discharges for patients diagnosed and treated for Obesity with Diabetes by location (3). This visual aid demonstrates communities at greatest need.

Pockets within the Towns of Moriah and Schroon are shown below to have residents experiencing the highest percentages of these discharge totals; 76-100%. The northeastern portion of the county including the Towns of Jay, Chesterfield, Willsboro and Elizabethtown along with the central Town of North Hudson follow comprising 51-75% of these discharges.



About This Map

This map depicts the percentage of inpatient discharges diagnosed and treated for obesity WITH type 2 diabetes. The percentage is calculated by dividing the number of inpatient discharges for obesity with type 2 diabetes within a zip code by the total number of inpatient discharges for obesity within the same zip code. When compared to PHIP's six-county North Country region as a whole (Clinton, Essex, Franklin, Hamilton, Warren, and Washington), Essex County's overall percentage of 47% is lower than the entire region's percentage of 48%.

Percent of Obese Inpatient Discharges with Type 2 Diabetes

- Lowest (0%)
- Lower (1–34%)
- Moderate (35–50%)
- Higher (51–75%)
- Highest (76–100%)

Lung Disease, Tobacco and Nicotine

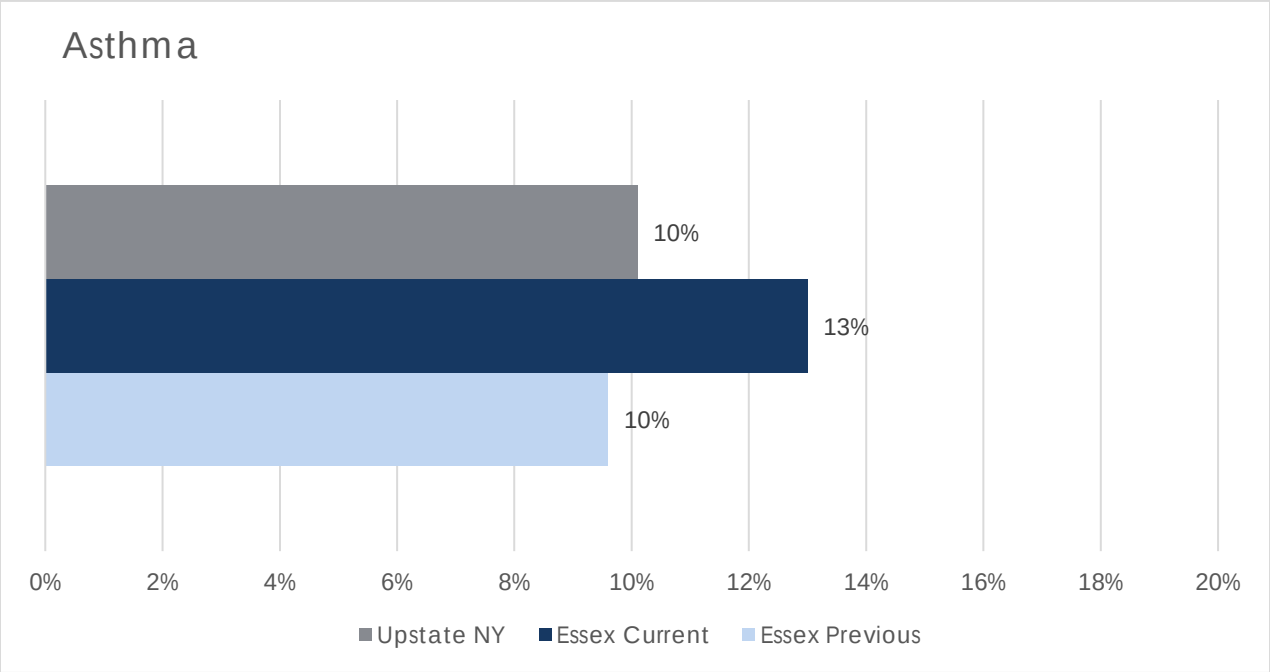
Asthma

WHY IT MATTERS (10)

- **Asthma** is a serious disease causing wheezing, trouble breathing & coughing
- It is a leading cause of hospitalizations for children
- Over a lifetime it can cause permanent lung damage

WHY IT'S A PRIORITY IN ESSEX COUNTY (39)

Latest available data demonstrates 13% of Essex County residents have Asthma; an increase from the previous assessment and higher than NYS (9.6%). Analysis of age groups for people with Asthma reveals that children ages 0-17 have the highest rate of Asthma in Essex County.



Respiratory Disease

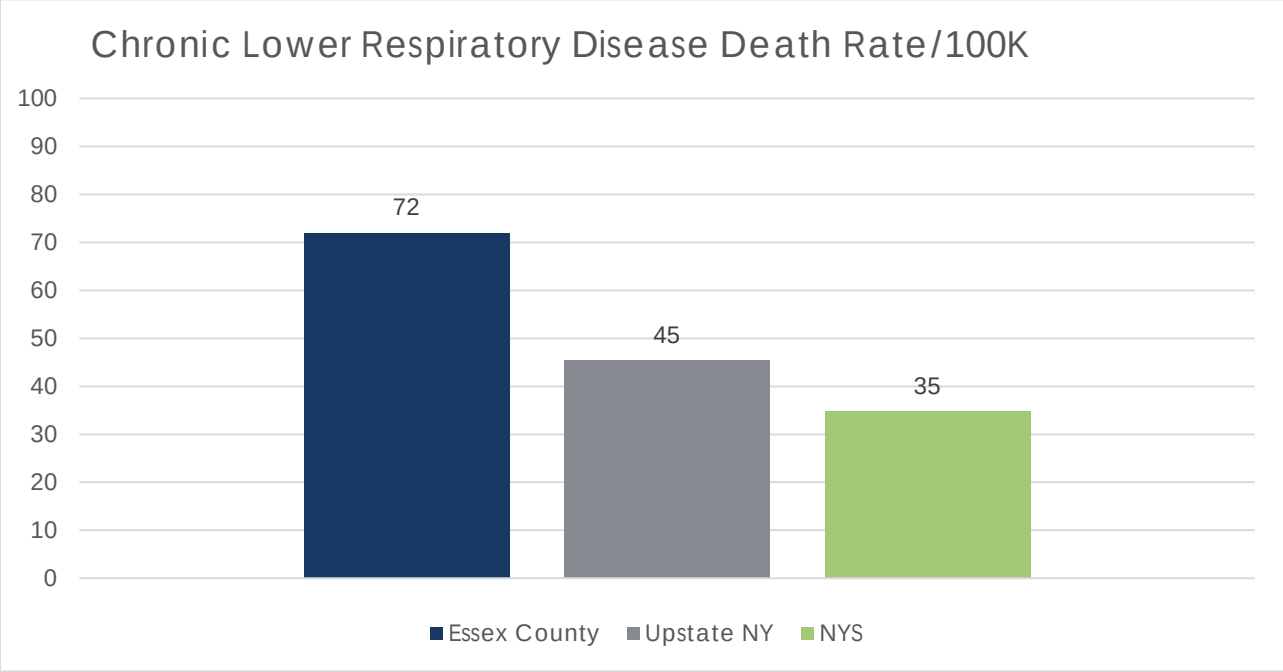
WHY IT MATTERS (10)

- **Respiratory Disease** is a leading cause of death in Essex County
- Smoking is **the** leading cause of disease including lung disease, heart disease & stroke.

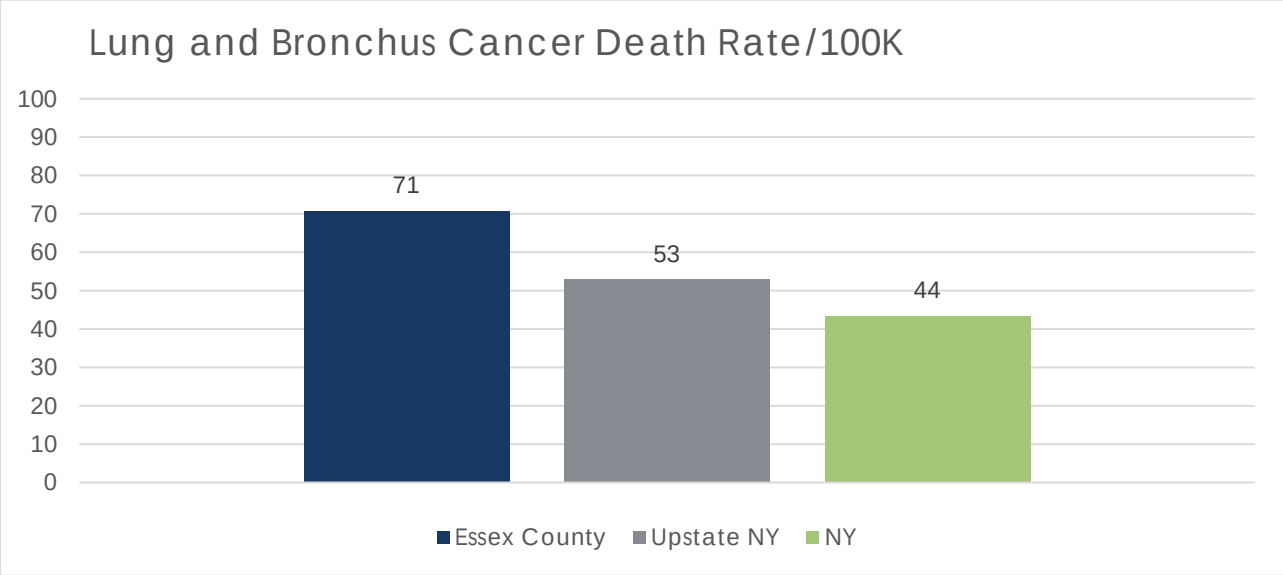
WHY IT'S A PRIORITY IN ESSEX COUNTY

Chronic Lower Respiratory Disease (CLRD) is one of the leading causes of death in Essex County (36). CLRD is a group of conditions that affect the lungs: chronic obstructive pulmonary disease (COPD), includes emphysema and chronic bronchitis; asthma; pulmonary hypertension; and occupational lung diseases. These conditions are most common among smokers (10).

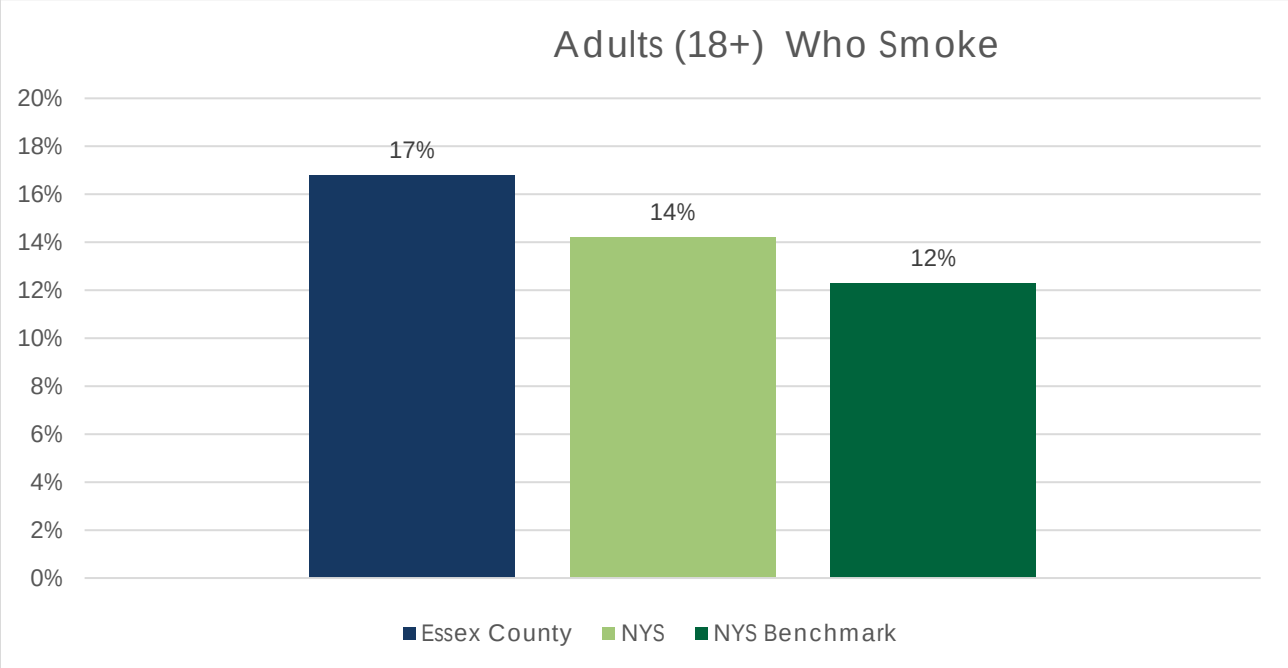
The chart below demonstrates the rate of 72/100K in Essex County is higher than the Upstate rate of 45/100K and double the NY rate of 35/100K (5).



Lung and Bronchus Cancers remain the leading type of cancer causing death in the US (10). In Essex County, the rate of this type of cancer deaths (71/100K) exceeds the Upstate NY rate (53/100K) and NYS rate (44/100K) as visualized in the cart below (5). Smoking is also the greatest risk factor for these types of cancers (10).



These disease rates correlate with Adults Who Smoke as demonstrated in the chart below. The percent of Smokers in Essex County, 17%, is on the decline. Yet it remains higher than NYS (14%) and the NYS benchmark (12%). (5)



E-cigarettes/Vaping Associated Lung Injury (EVALI)

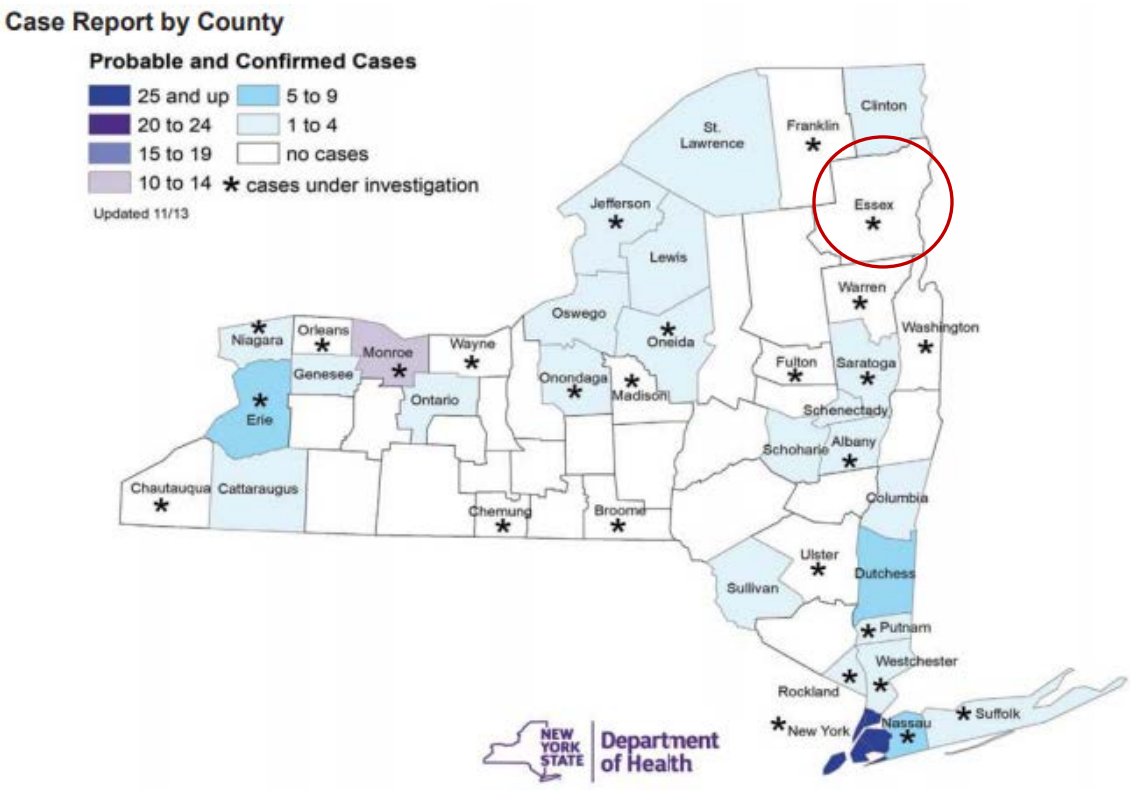
WHY IT MATTERS (10, 48)

Since 2014 e-cigarettes have become the most commonly used tobacco product among youth

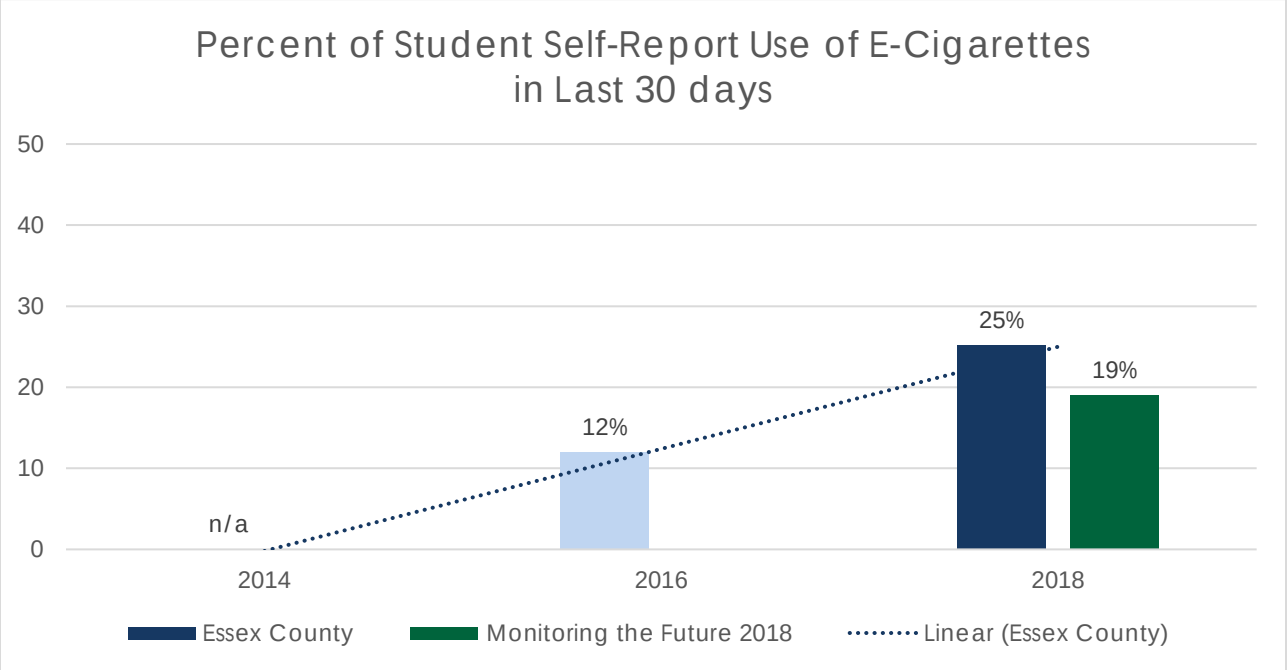
- outbreak of vaping-associated pulmonary illnesses and deaths occurs in NYS & the US, 2019
- current outbreak investigation reveals 62% of patients are under the age of 25

WHY IT'S A PRIORITY IN ESSEX COUNTY

Case reports from across NYS reveal residents of Essex County are included as part of the on-going investigation of EVALI (48).



Analysis of the local 2018 New York Prevention Needs Assessment Survey sponsored by the Essex County Youth Bureau demonstrates self-reports of use (students in grades 7-12) increased from 12% in 2016 to 25% in 2018 (see the chart below). Data in this report generally demonstrates an increase in the percent of youth using these products as they age from 7th to 12 grades; 10% in 7th grade to 37.7% in 12th grade. (21)



Priority Health Issue: Well-Being & Substance Use Prevention

Well Being and Substance Use Prevention is the second issue examined in-depth in this report. Sub-categories of alcohol; mental health; and opioids and other drugs were isolated as elements contributing to mental health and substance use disorders in Essex County.

These subsections frame each factor in terms of "Why it Matters" and "Why it's a Priority", providing the universal health consequences of each factor, as well as the health impacts that are distinctly experienced by Essex County.

Alcohol

WHY IT MATTERS (10)

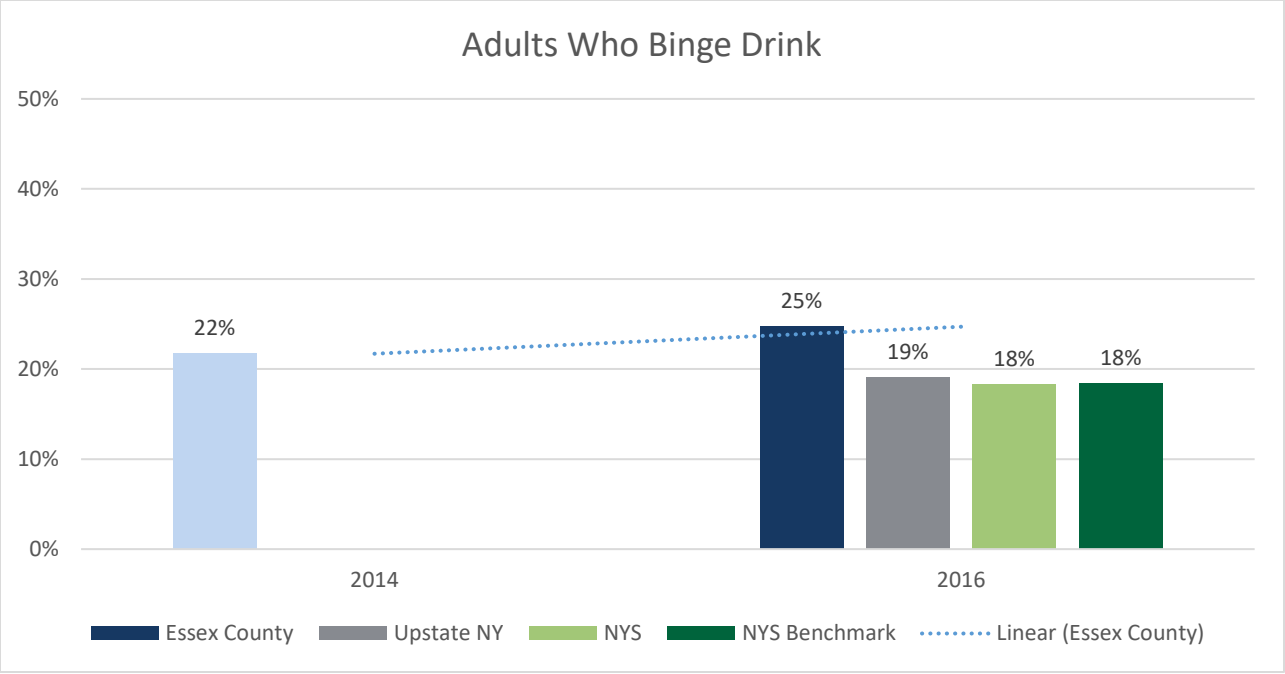
Excessive alcohol use results in the following short & long term health effects:

- Motor vehicle accidents, drownings, violence
- Risky sexual behaviors-assault & unintended pregnancy, STIs
- Chronic conditions:
  - High BP, Stroke, Liver Disease, Digestive problems & some Cancers
- Mental health problems:
  - Depression, Anxiety
- Social problems:
  - Family disputes, financial loss, legal & employment problems

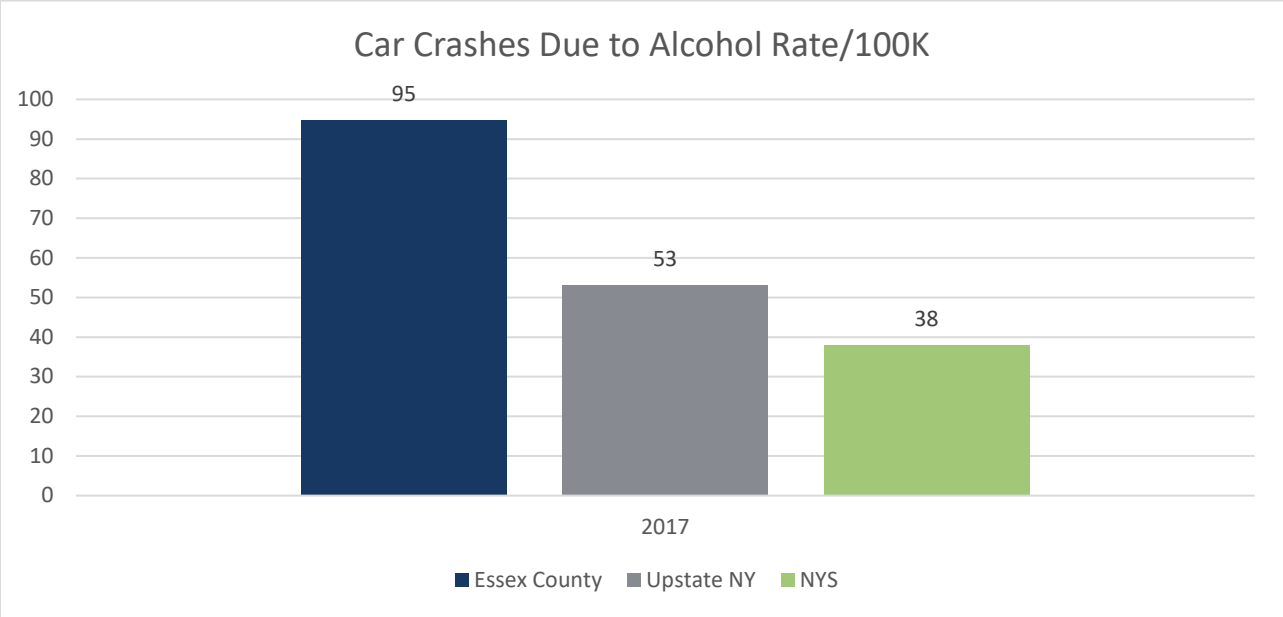
WHY IT'S A PRIORITY IN ESSEX COUNTY

The most recent data available shows 25% of adults in Essex County report binge drinking (5).

This is a slight increase from previous assessments showing 22% in 2014. As demonstrated in the chart below when compared to Upstate NYS, NYS and the NYS Benchmark, the percent of binge drinking adults in Essex County is higher.



Short term negative impacts of excessive alcohol use are evident in the rate of car crashes due to alcohol in Essex County. At a rate of 95/100K; the Essex County rate is 2 ½ times the NYS rate of 38/100K. (5)



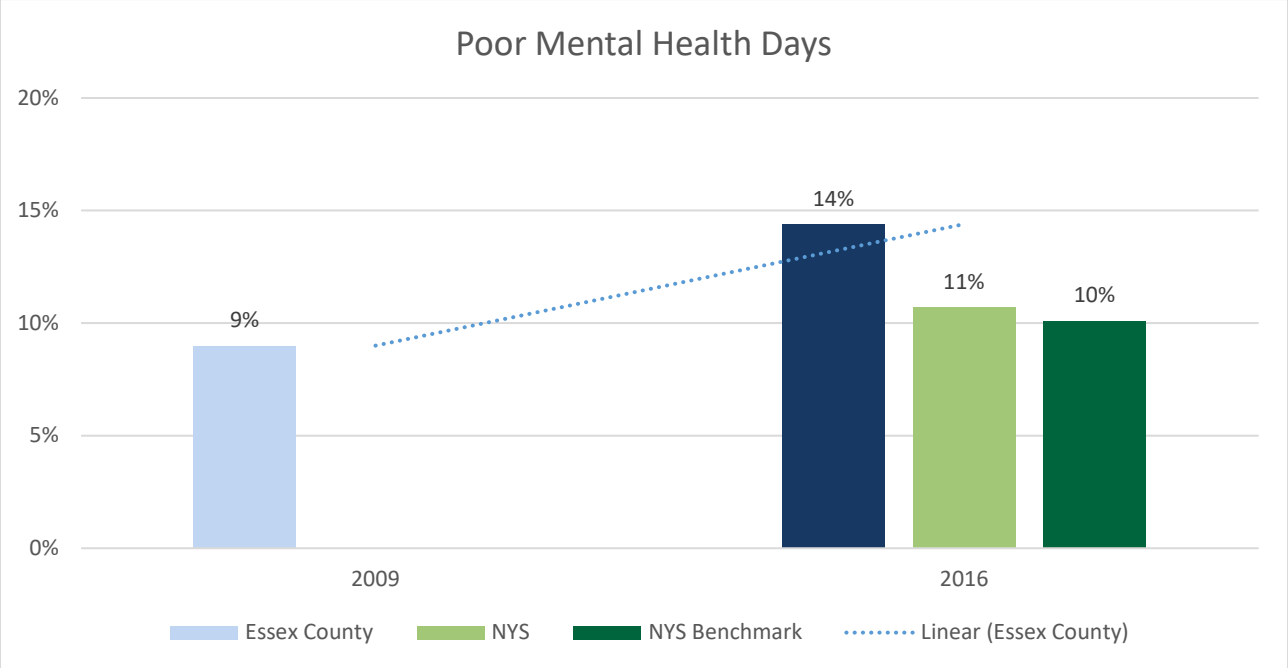
Mental Health

WHY IT Matters (10)

- Mental health impacts includes emotional, psychological & social well-being
- It affects how to think, feel and act
- It affects how we handle stress, relate to others & make choices that impact our physical health & other aspects of our lives
- It includes a range of periodic poor mental health to mental illness
- Ongoing poor mental health or poorly managed illness can lead to death by suicide

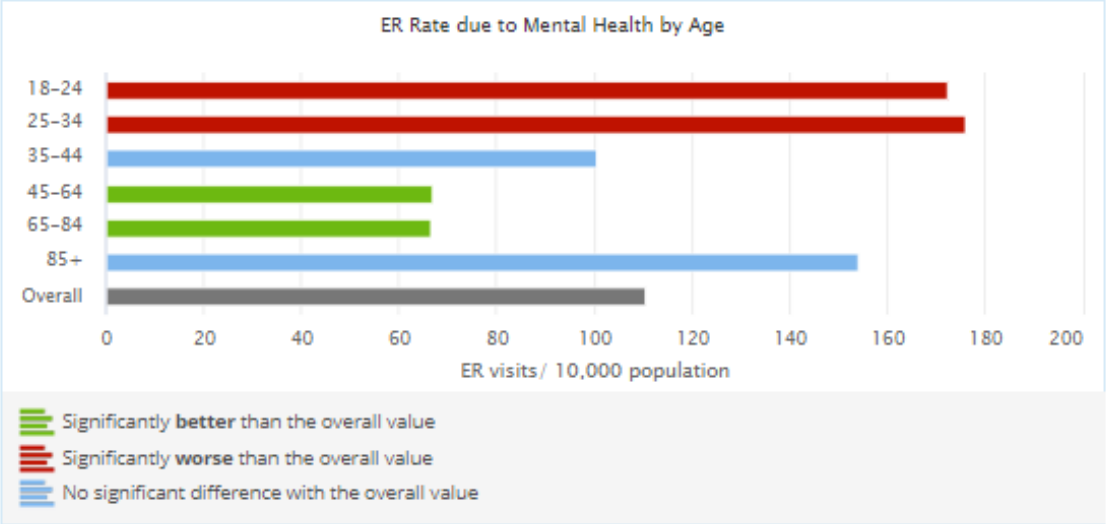
WHY IT'S A PRIORITY IN ESSEX COUNTY

Adults reporting poor mental health days is 14%. This exceeds NYS (11%) and the NYS Benchmark (10%) (See Figure X below). Trend analysis of this data demonstrate an increase of 5 percentage points over 7 years: 9% in 2009 to 14% in 2016 (See the chart below). (5)

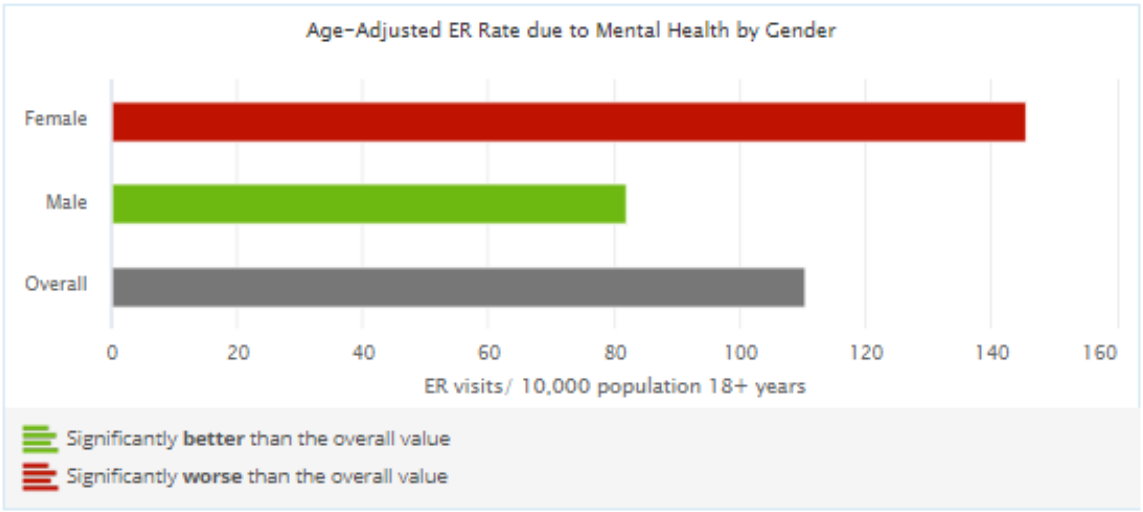


The use of Emergency Rooms for mental health visits was one indicator for which more granular data for Essex County was available (26).

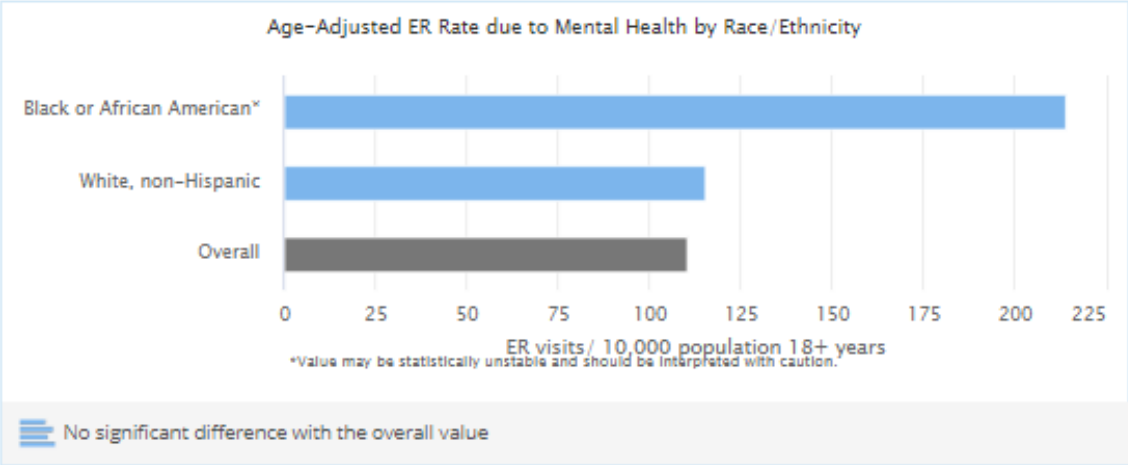
When considering age, the greatest discrepancy from the overall value is found to be in younger adults; that is, people ages 25-34 followed by people 18-24 as depicted in the chart below.



Gender analysis also reveals a statistically significant difference from the overall for females as demonstrated in the chart below.

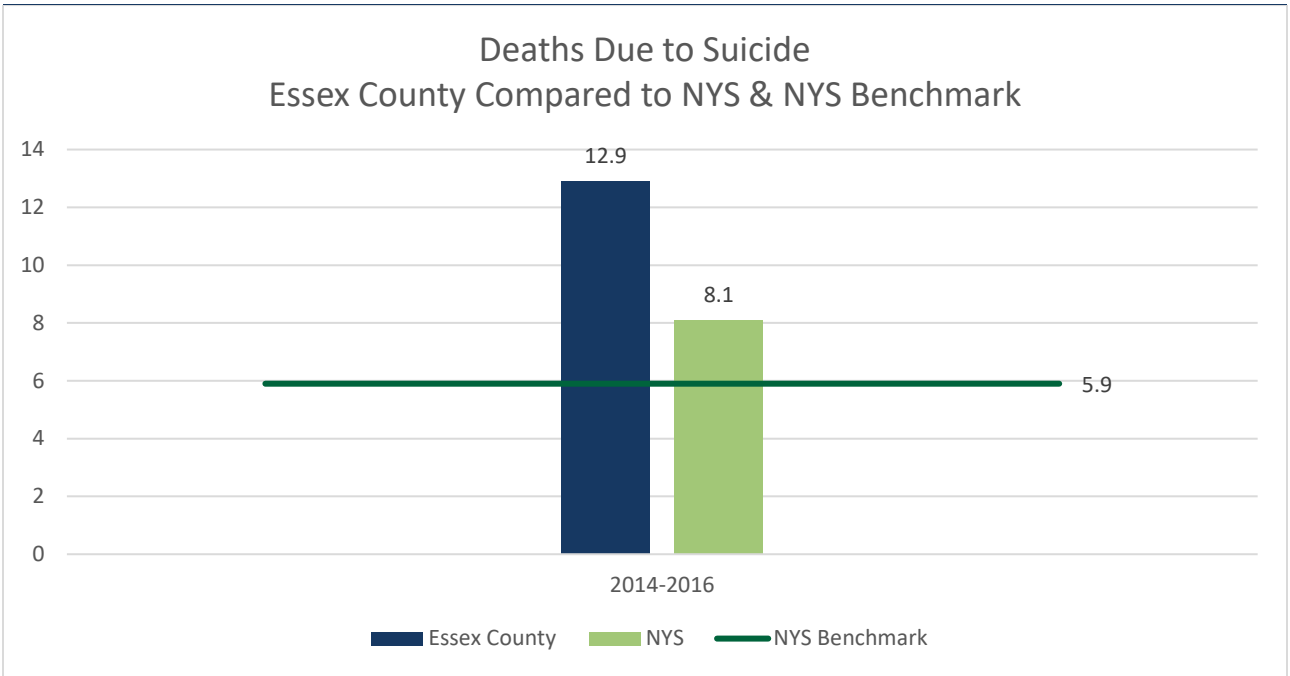


Race/Ethnicity analysis suggests a higher rate for people that are Black/African American (see the chart below). However, it is notable that this value is statistically unstable. (26)



The most recent Vital Statistics data published (May 2018) for NYS demonstrate deaths due to suicide in Essex County (12.9/100K) have improved since the previous assessment. However the rate is higher than the NYS rate (8.1/100K) and consistently higher than the NYS Benchmark (5.9/100K). (5)

Examination of NYS sub-population data reveals deaths by suicide impacts more men than women, and those in the age range of 45-64 (48). Because the number of deaths by suicide is small, sub-population data is not available for Essex County. However it is reasonable to consider that men ages 45-64 are at increased risk compared to the general population if applying the NYS analysis here.



Opioids and Other Drugs (47)

WHY IT MATTERS (31, 10)

Nationally,

- deaths involving prescription opioids have increased since 1999
- deaths involving heroin have rapidly increased since 2010
- deaths involving synthetic opioids have significantly increased in since 2013
  - includes illicitly-manufactured fentanyl (IMF) and fentanyl analogues as found in combination with heroin, counterfeit pills, and cocaine
- most people who report prescription opioid misuse in current cohorts initiated use in their early to late 20s
- the proportion of babies born with neonatal abstinence syndrome (NAS) increased five-fold from 2000 to 2012
- misuse of opioids and other drugs pose significant health, social and economic complications for individuals, families and communities

NYSDOH responded to the growing opioid crisis with a significant improvement in opioid-related data through the Opioid Prevention Program's Opioid Dashboard in 2019 (47). This is data from multiple places including hospital discharge, the Prescription Monitoring Program & NYS Office of Alcohol and Substance Abuse Services (OASAS) and allows communities to better understand the local burden related to opioids and other drugs.

WHY IT'S A PRIORITY IN ESSEX COUNTY

Promote Well-Being & Prevent Mental Health and Substance Use Disorders

was the top NYSDOH Prevention Agenda Priority area selected by Stakeholders

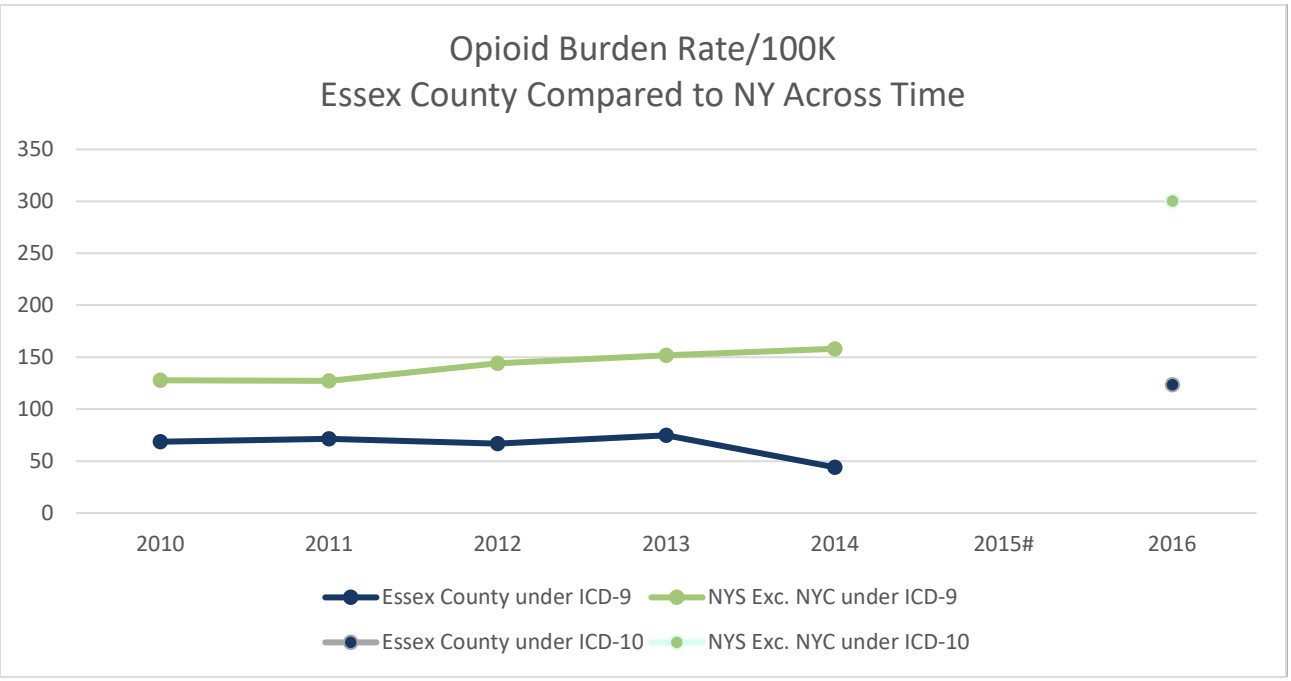
60%

of residents identified substance abuse as a health challenge in the community

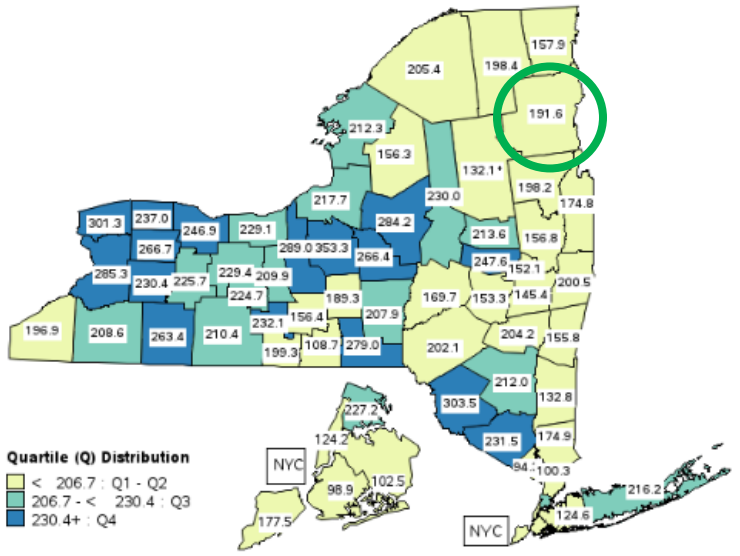
Opioid Burden is a composite indicator including outpatient ED visits and hospital discharges for non-fatal opioid overdose, abuse, dependence, and unspecified use; and opioid overdose deaths. As demonstrated in the chart below, the opioid burden in Essex County remains consistently below that of NY excluding NYC. The 2015 year is excluded due to the data source transitioning in this year from ICD-9-CM to ICD-10-CM diagnosis codes. As these codes are not comparable, an annual rate for 2015 cannot be calculated. It is not recommended to compare 2016-and-forward data with 2014-and-prior data. (47)

Additional data analysis reveals the Opioid Prescription Rate in Essex County shows trend improvement since 2013 to the most current rate available, 2017 of 572.6/1K. This 2017 rate is lower than the North Country rate (623.3/1K) though higher than NY (361.3/1K). (47)

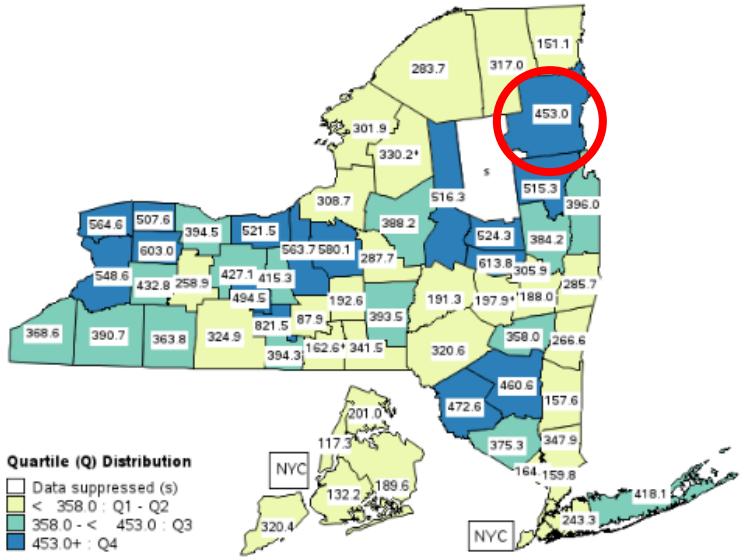
Opioid Overdose Deaths data was also examined for years 2010-2017. This data demonstrates a general trend increase though data points are considered statistically unstable with less than 10 incidents each year. (47)



Examination of Emergency Department Visits for Any Drug data, 2016 shows the rate in Essex County (191.6/100K) to be higher than the state average (171.0/100K) though within the first 2 (lowest risk) quartiles as demonstrated in the figure below. (47)



Further analysis of this data to find sub-populations at greatest risk reveals young adults, those ages 18-24, have the highest rate of Emergency Department Visits for Any Drug as depicted in the figure below. (47)



Priority Issue: Healthy Women, Infants and Children

Healthy Women, Infants and Children is the third priority area comprehensively examined as part of the CHA process. The significant elements of this analysis are noted in this report.

The data revealed that the sub-categories of unintended pregnancies, teen pregnancy, early prenatal care, and child health are factors that influence the health of women, infants, and children in Essex County. These subsections frame each factor in terms of "Why it Matters" and "Why it's a Priority", citing the universal health consequences of each factor, as well as the health impacts that are distinctly experienced by Essex County.

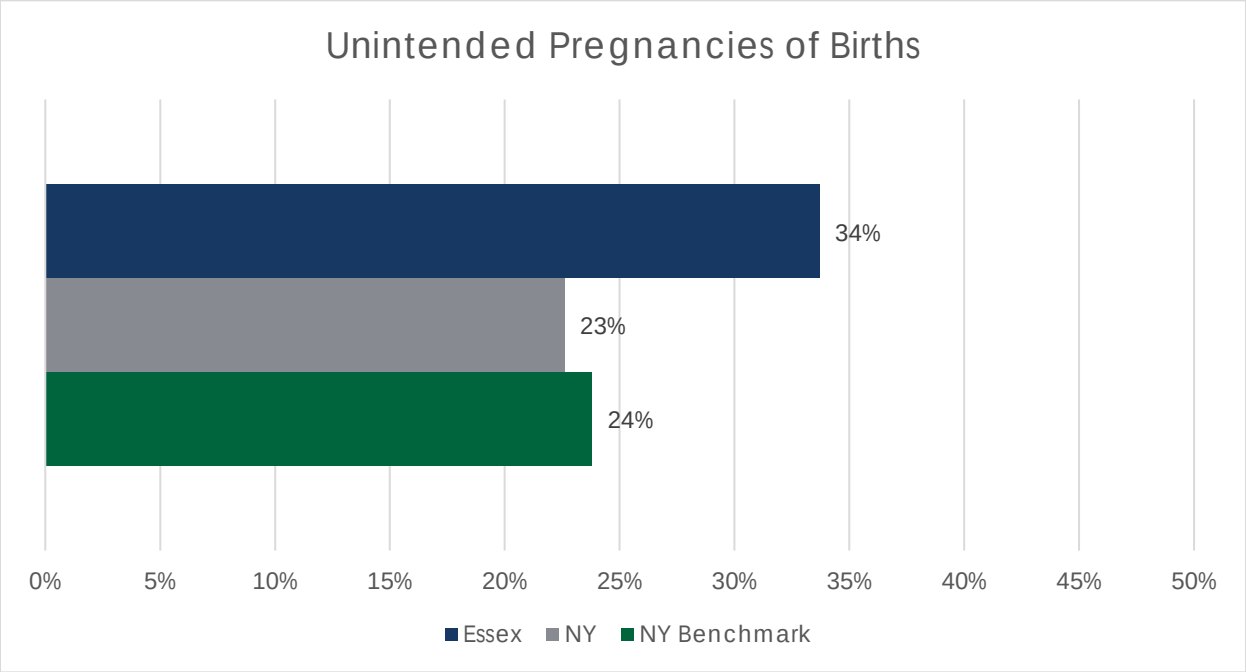
Unintended Pregnancies

WHY IT MATTERS (27)

- Unintended pregnancies can contribute to physical, psychological, emotional and social woes for moms & babies
- It often means less adequate prenatal care, low birth weight, increased risk of infant mortality, child abuse and developmental deficits
- It has been associated with increased socio-economic impacts on communities as well as:
  - increased need/use of healthcare and social services
  - decreased educational attainment and economic contributions of mothers & babies

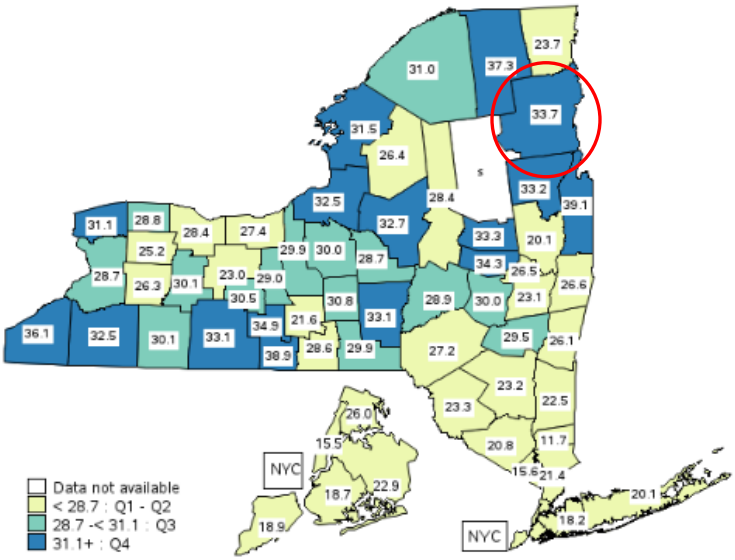
WHY IT'S A PRIORITY IN ESSEX COUNTY

Thirty-four percent (34%) of births are the result of unintended pregnancies. (5)



The percent of unintended pregnancies in Essex County is 10 percentage points higher than the NY benchmark (24%). As indicated in the visual aid of the map (below) Essex County falls within the 4th quartile (furthest from the benchmark) for this indicator, coded as dark blue for locations with the highest rates. (5)

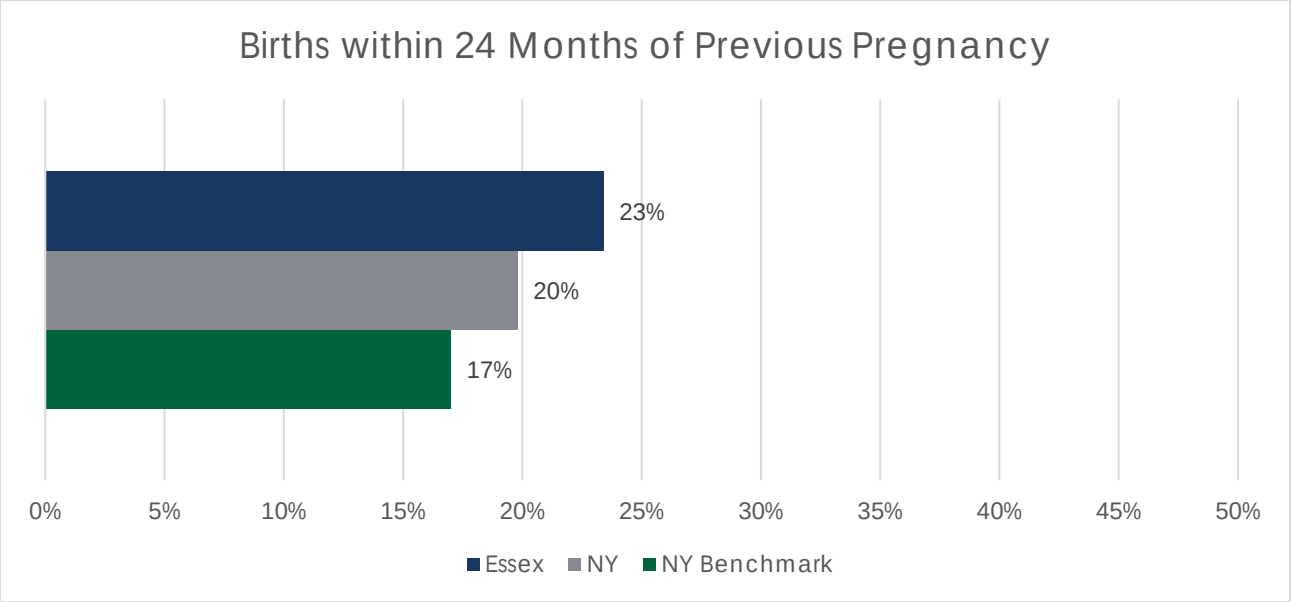
Examination of this data to determine if there are disparities reveals (48):



- Data by race is suppressed due to very small numbers (less than 10)
- Medicaid to non-Medicaid ratio in Essex County (1.10) is better than the NY average (1.71) and NY Benchmark (1.54).
- Communities with the highest rates are the towns of Moriah, Crown Point, Ticonderoga and Schroon.

Pregnancy timing is an important piece of family planning discussions that can be conducted during prenatal or post-natal health visits. Close proximity of births can be physically, mentally, emotionally and financially stressful for families.

In Essex County, 23% of births are within 2 years of a previous pregnancy; 5 percentage points higher than the NY benchmark. Sub-population analysis demonstrates communities that fall within the 4th quartile/furthest from the benchmark, are the towns of Bloomingdale and Schroon. (48)



Teen Pregnancy

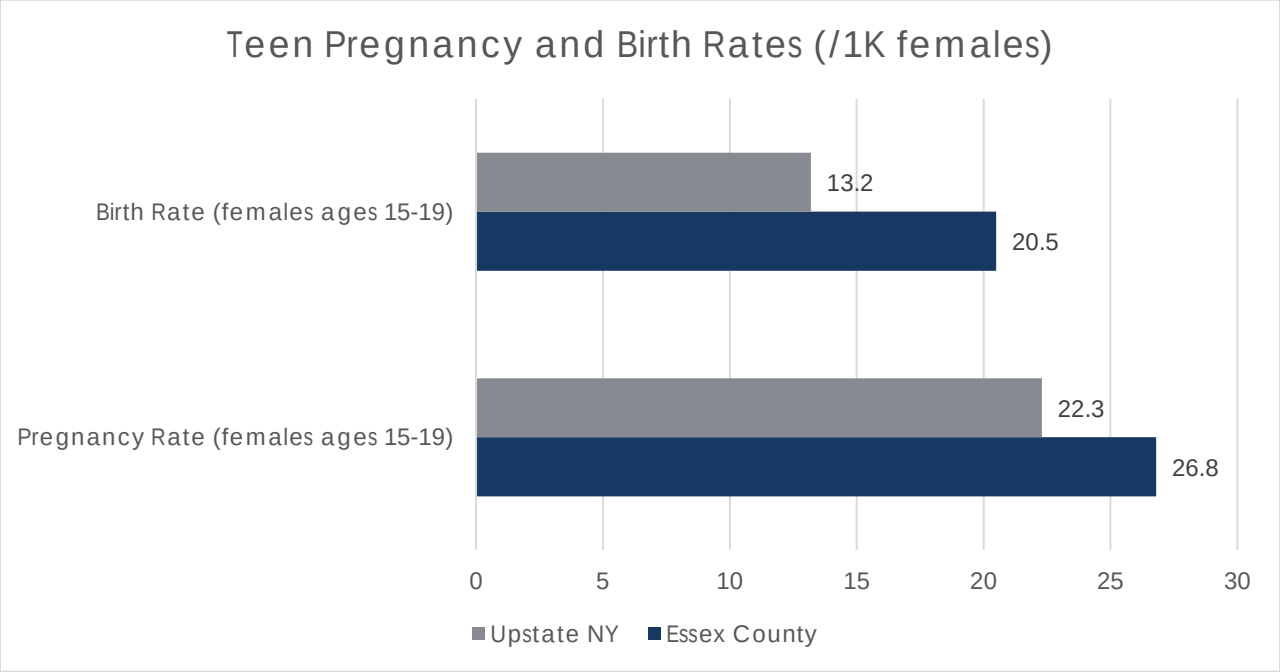
WHY IT MATTERS (10)

Teen pregnancies bring substantial social & economic impacts for mothers, their babies & communities:

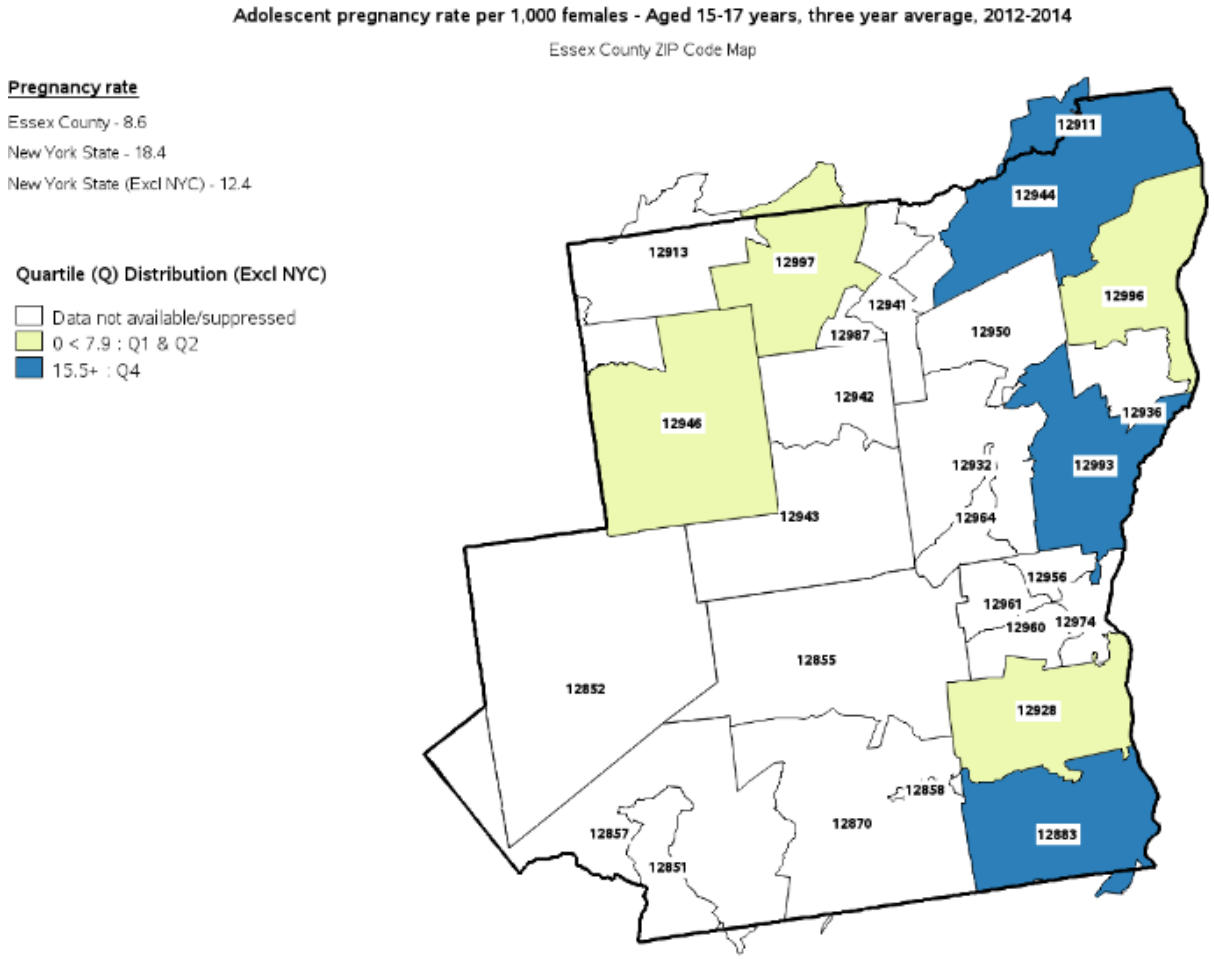
- Increased health risks for moms & babies
- Negative impact on social & educational development of moms & babies
- Negative impact on earnings potential
- Increased need of social services

WHY IT'S A PRIORITY IN ESSEX COUNTY

Pregnancies include births, abortions and spontaneous fetal deaths to females ages 15-19. Essex County teen pregnancy rate falls within the 4th quartile (farthest from the benchmark). (5)



Examination of sub-county data demonstrates 4th quartile rates in the communities of Chesterfield, Westport & Ticonderoga as depicted in the figure below. (48)



Early Prenatal Care

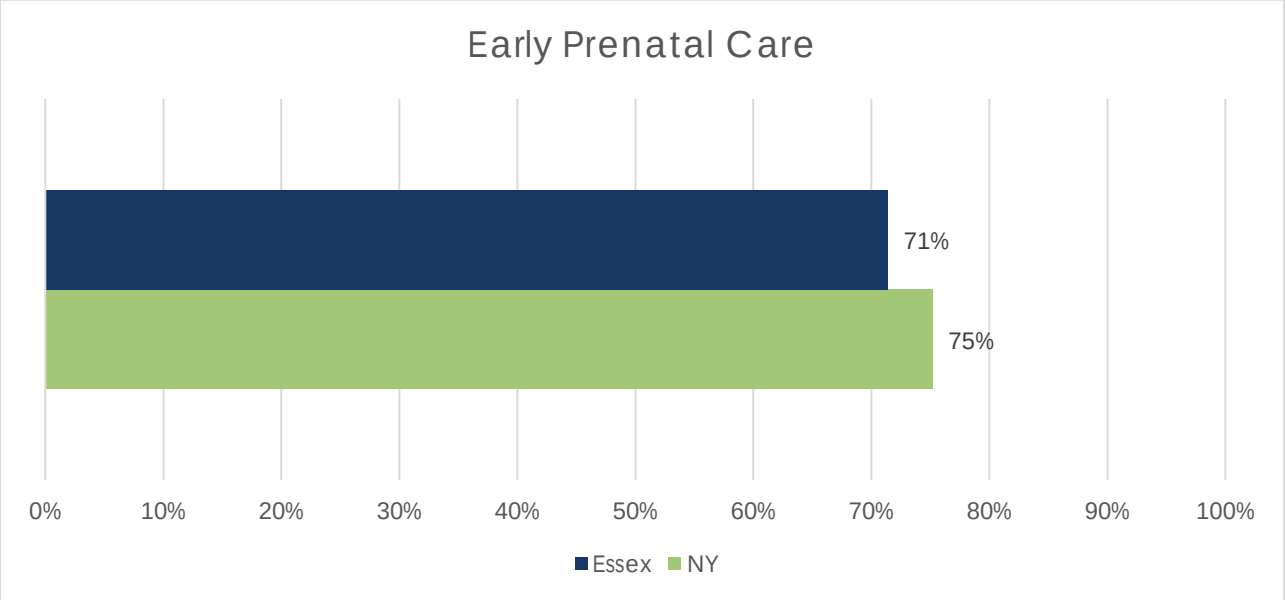
WHY IT MATTERS (27)

Early prenatal care

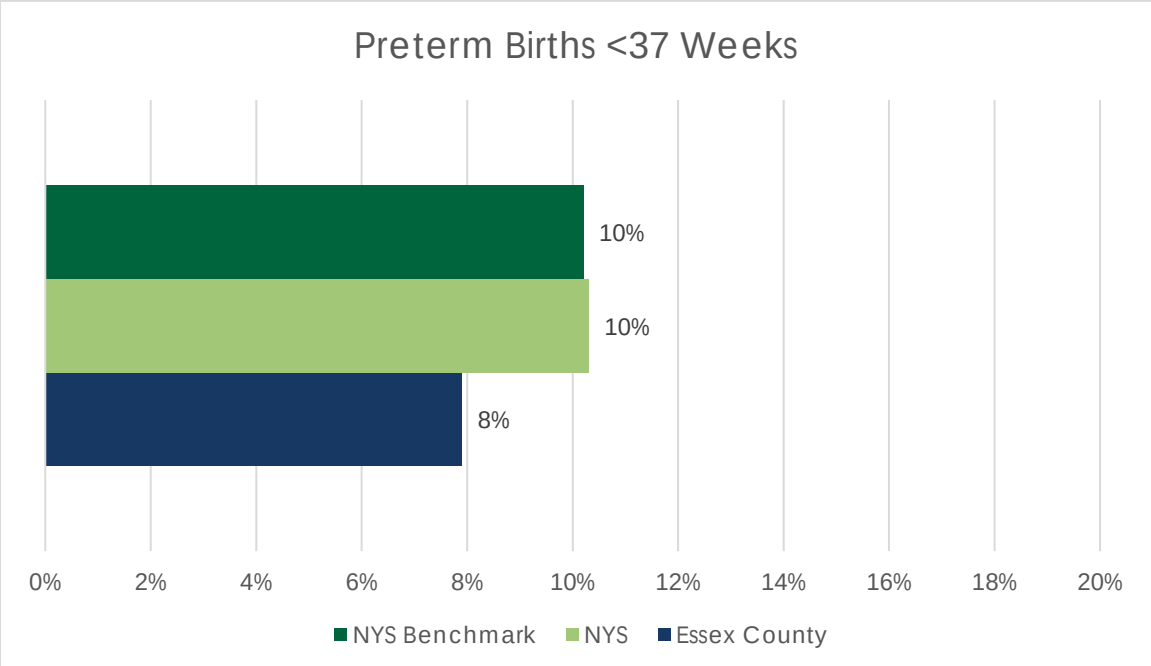
- ensures the best possible outcomes for mothers, babies and children
- allows for education and planning for preventing problems related to pregnancy:
  - vitamins, minerals & nutrition;
  - vaccinations;
  - medications & drug use;
  - environmental risks and travel exposures.
- ensures women access healthcare when needed for pregnancy related concerns:
  - high blood pressure;
  - gestational diabetes;
  - bleeding or clotting.
- ensures planning for babies' arrivals:
  - newborn screenings, vaccinations;
  - breastfeeding, infants and child nutrition;
  - home and vehicle safety;
  - child care and
- impacts the physical and cognitive development of infants that starts during pregnancy
- impacts the psychological and social well-being of families and
- predicts a future public health challenges families, communities, and the health care system.

WHY IT'S A PRIORITY IN ESSEX COUNTY

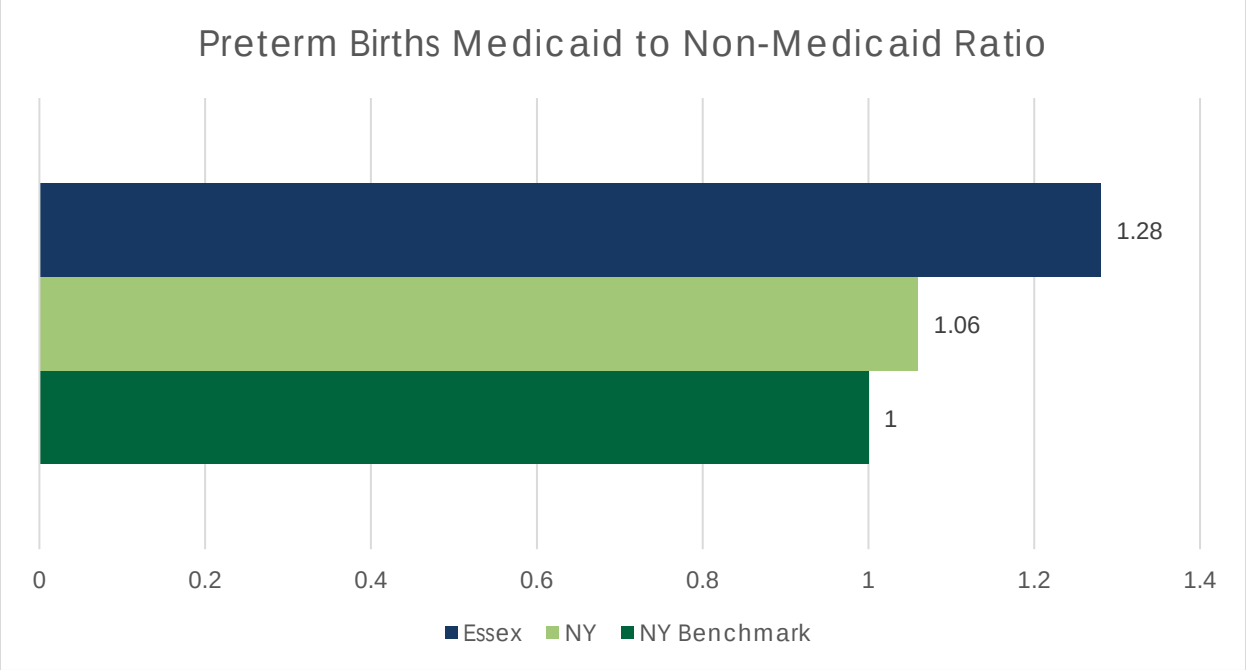
There is a lower percent of prenatal care received by women in Essex County (71%) compared to NY (75%). (5)



Essex County has a lower percent of Preterm Births (8%) than the NY average (10%) and performing better than the NY Benchmark (10%); see the chart below. (5)



However, examination of the ratio of preterm births Medicaid to Non-Medicaid in Essex County reveals a ratio (1.28) that exceeds the NY average (1.06) and the NY Benchmark (1.0) as depicted in the chart below. (5)) This indicates that more babies are born prematurely to women with Medicaid than women with private insurance.



Child Health Indicators

Why It Matters (27)

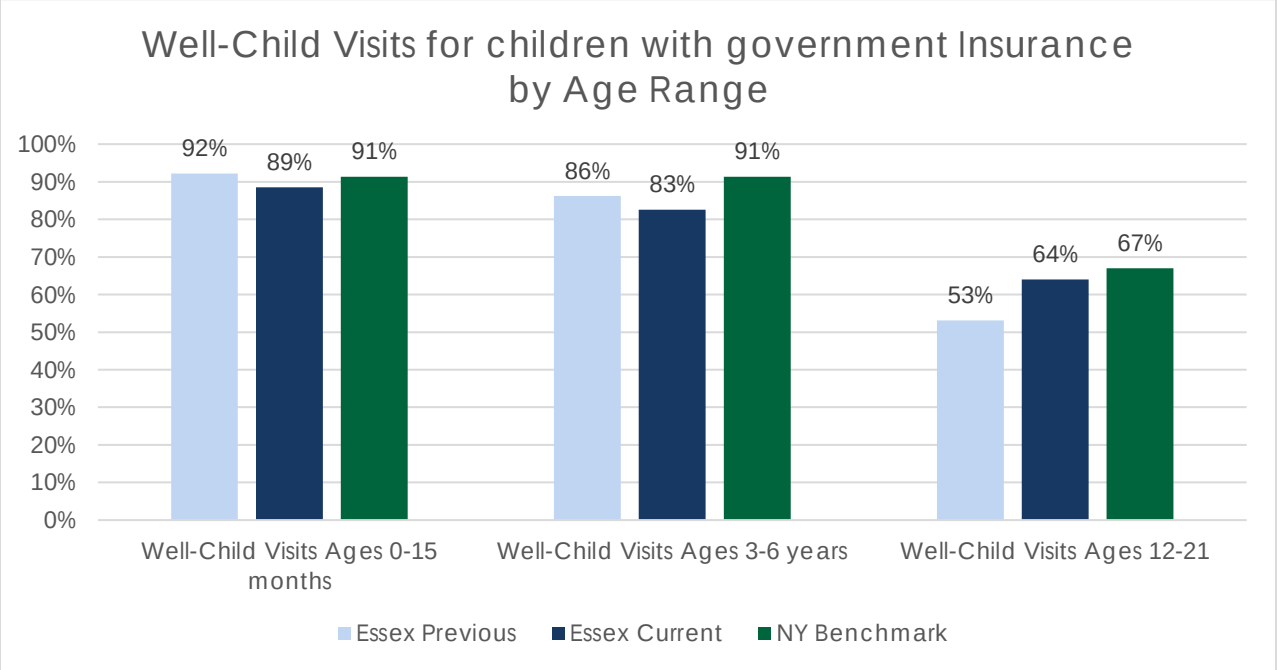
Children having a medical home and receiving annual well-child visits ensures age-specific care including:

- assessment of childhood physical & cognitive development;
- education for lifestyle and behavioral health factors;
- recommendations for preventive health care such as vaccinations & lead screening; and
- coordinated health care and/or referral for specialty care/services.

WHY IT'S A PRIORITY IN ESSEX COUNTY (5)

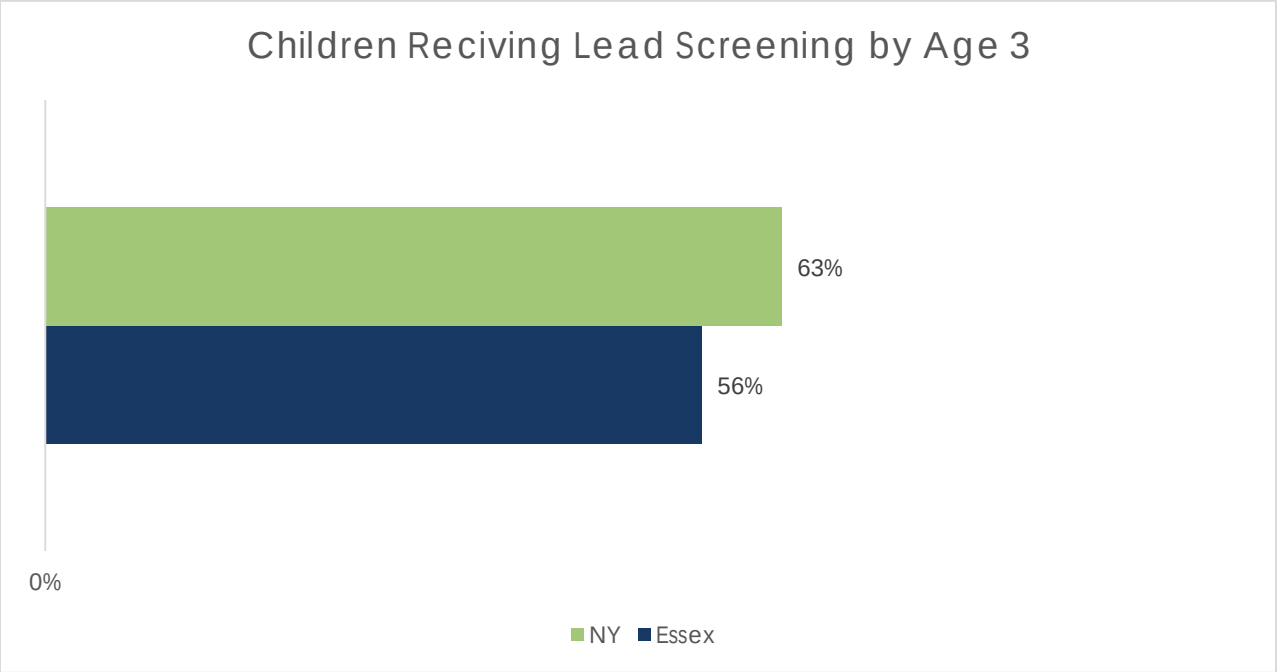
Analysis of data for Essex County reveals:

- well child visits have decreased since the previous assessment from 92% to 89% for those ages 0-15 months and 86% to 83% for those ages 3-6 years;
- well child visits for youth 12-21 increased since the previous assessment from 53% to 64%;
- NY Benchmarks for well child visits are not met for any age group as depicted in the chart below.



Lead Screening

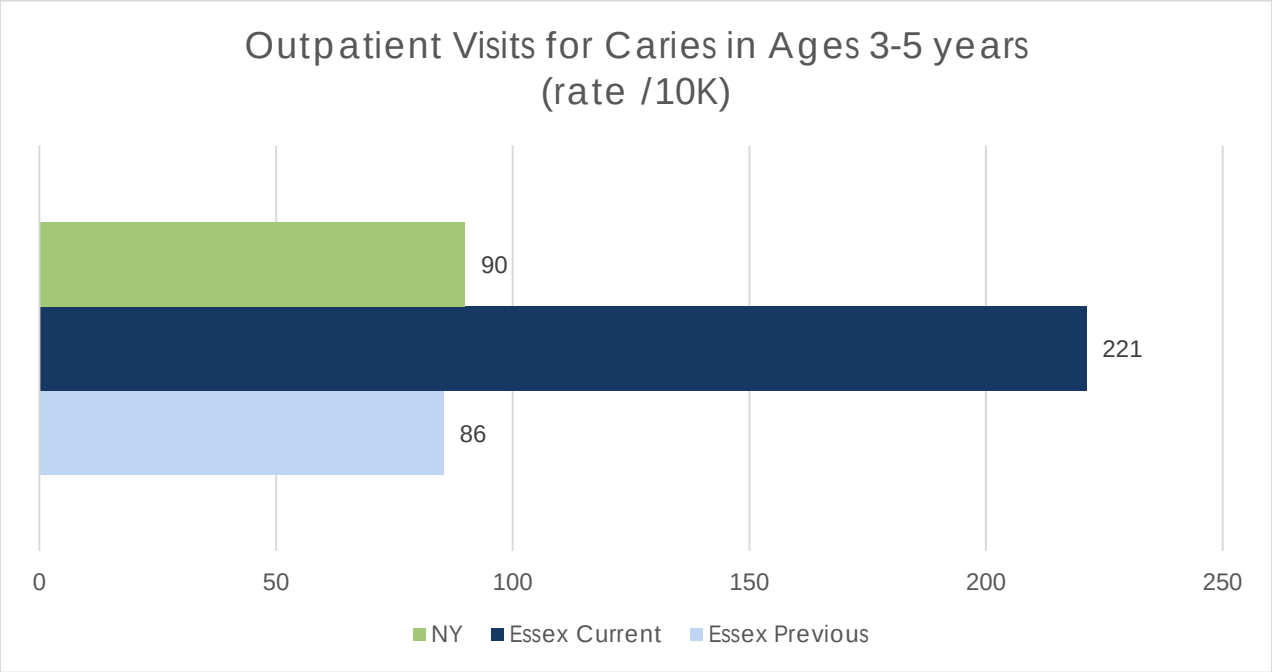
It is recommended that children receive lead testing at least twice by the time they are 3 to identify risk for lead poisoning exposures and risks including childhood development. While the NY average for meeting this lead screening standard is 63%, Essex County is less; 56%. (5)



Dental Caries

Children are susceptible to dental caries (tooth decay) as soon as their baby teeth appear. Problems related to dental caries include pain, loss of teeth, impaired growth, and negative quality of life. Decay is primarily caused when bacteria on teeth metabolize dietary sugars and produce acids that demineralize the teeth. Water fluoridation or fluoridation treatments are recommended to improve the resistance of tooth enamel to the breakdown caused by acid decay. (32)

There are no public water systems that are fluoridated in Essex County. (41)



Health Indicators by Sub-Populations

Health, what it means, and the underlying factors that are most significant to any one individual can change depending on age, gender, stage of life, or any number of other considerations.

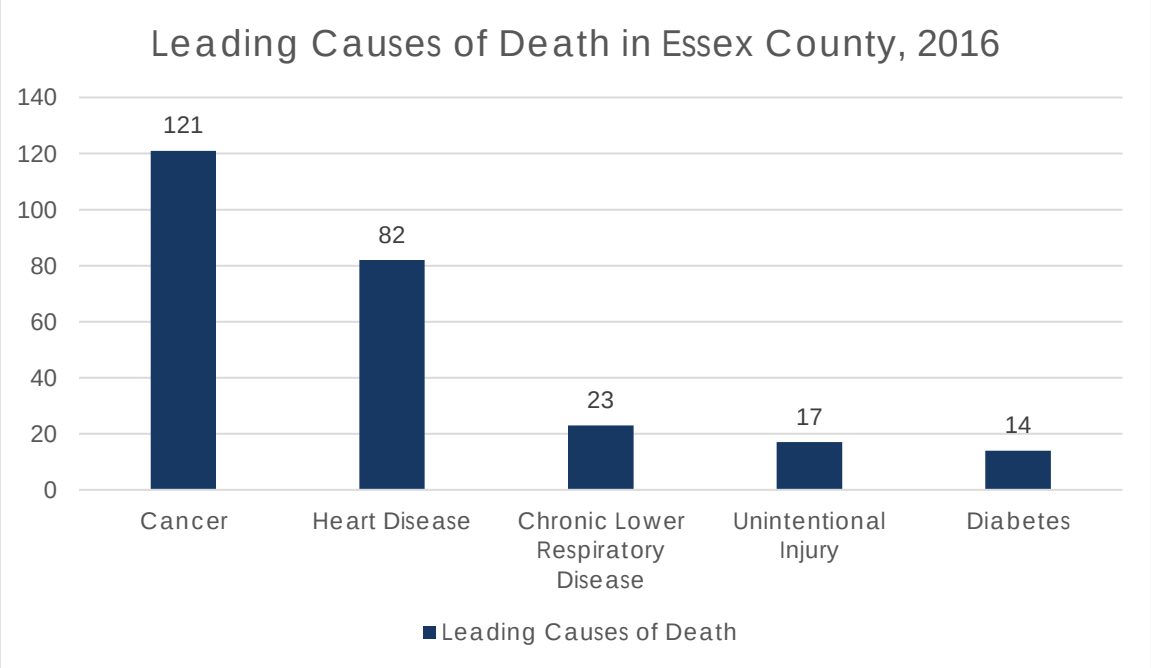
This section starts with a view of the leading causes of death in Essex County followed by an analysis of specific health indicators that may contribute to disparate health outcomes of sub-populations in Essex County. Sub-populations examined here are:

- Women and Infants
- Children and Adolescents
- Adults
- Older Adults.

Leading Causes of Death (36)

There are approximately 400 deaths per year in Essex County.

The top 2 leading causes of death remain cancer and heart disease.



Women & Infants

Cancer Screenings and Cases (5)

Screenings for cancers specific to women are lower than the NYS comparison; rates are higher.

INDICATORS	Essex County Trend	Essex County Previous	Essex County Current	Essex County compared to Upstate NYS	Upstate NYS
Breast Cancer screening %	▼	83.0	78.4	●	79.2
Breast Cancer cases rate/100K	▲	151.7	201.5	●	175.9
Cervical Cancer screening %	N/A	N/A	93.1	●	83.5
Ovarian Cancer cases rate/100K	▼	15.9	14.4	●	16.0

Pregnancies and Births (5)

Indicators related to pregnancies and births are generally trending poorly and are worse than NYS comparison or do not meet the NYS Benchmark.

INDICATORS	Essex County Trend	Essex County Previous	Essex County Current	Essex County compared to NYS Benchmark	NYS Bench mark
Unintended Pregnancies of Births %	▲	31.7	33.7	●	23.8
Unintended Pregnancies of Births Medicaid to Non-Medicaid* ratio	▼	1.82	1.10	●	1.54
Births within 24 months of previous birth %	▲	19.5	23.4	●	17.0

				Essex County compared to Upstate NYS	Upstate NYS
Early prenatal care %	▼	73.3	71.4	●	77.0
Preterm Births %	▼	8.2	7.9	●	10.2
Premature Births Medicaid to Non-Medicaid ratio	▲	1.23	1.28	●	1.00
Births to women 35+ %	▲	14.4	15.6	●	20.2
Newborn Drug-related hospitalizations rate/10K	▲	101.6	106.1	●	140.8

Breastfeeding (5)

The percent of women reporting breastfeeding in the delivery hospital has decreased though remains better than the NYS Benchmark.

INDICATORS	Essex County Trend	Essex County Previous	Essex County Current	Essex County compared to NYS Benchmark	NYS Bench mark
Breastfed in delivery hospital %	▼	75.0	65.3	●	48.1
Breastfed in delivery Hospital Medicaid to Non-Medicaid** ratio	▲	.86	.87	●	.66

WIC Indicators (18)

Several WIC indicators – first trimester prenatal enrollment, breastfeeding initiation and exclusively breastfeeding demonstrate a poor trend and fare worse than NYS as a comparison.

INDICATORS	Essex County Trend	Essex County Previous	Essex County Current	Essex County compared to NYS	NYS
Prenatal enrollment in the first trimester %	■	51.2	51.1	●	37.2
High maternal weight gain %	▼	41.4	37.3	●	35.2
Breastfeeding initiation %	▼	79.6	77.3	●	83.4
Exclusively breastfed at 6 months %	▼	17.7	6.3	●	9.6

Children and Adolescents

Household/Family

Household and family indicators demonstrate poor trends and are faring worse than the NYS comparison for reports of child abuse/maltreatment and children in foster care.

INDICATORS	Essex County Trend	Essex County Previous	Essex County Current	Essex County compared to NYS	NYS
Single Parent Households %(63)	▼	13.2	7.9	●	8.9
Report of Child Abuse/Maltreatment rate/1K (28)	▲	18.6	19.3	●	17.1
Children in Foster Care rate/1K (28)	▲	4	5	●	3.0

Healthcare

The percent of children with health insurance is closer to the NYS Benchmark than ever before.

Well child visits generally trend poorly and fare worse than the NYS comparison or benchmark. Childhood immunization rates have increased, though do not yet reach NYS Benchmarks.

INDICATORS (42, 48)	Essex County Trend	Essex County Previous	Essex County Current	Essex County compared to NYS Benchmark	NYS Bench mark
Children with Health Insurance %	▲	95.8	96.9	●	100
Well Child Visits (0-15 months) %	▼	92.2	88.5	●	91.3
Well Child Visits (ages 3-6) %	▼	86.2	82.6	●	91.3
Well Child Visits (ages 12-21) %	▲	53.1	64.0	●	67.1
Childhood Immunizations %	▲	61.5	73	●	80
Females with HPV Vaccine (ages 15-19) %	▲	24.7	34.2	●	50

				Essex County compared to Upstate NYS	Upstate NYS
Lead Screening by 3 years (2 screenings) %	▲	11.3	56.0	●	55.9

Dental Health (5)

Dental health indicators demonstrate a poor trend and close or worse when compared to NYSDOH.

INDICATORS	Essex County Trend	Essex County Previous	Essex County Current	Essex County Compared to Upstate NYS	Upstate NYS
One dental visit within the year, Medicaid Enrollees ages 2-20 %	▼	58.7	47.9	●	48.0
Dental Caries (decay) Outpatient Visits (ages 3-5) rate/10K	▲	85.5	221.3	●	119.7

Injuries

The rate of Emergency Department (ED) visits for injuries in young children is trending higher and is above the NYS benchmark. Work-related ED visits in adolescents are lower than previously reported; however, they remain above the NYS benchmark.

INDICATORS (5)	Essex County Trend	Essex County Previous	Essex County Current	Essex County compared to NYS Benchmark	NYS Bench mark
ED Visits for Falls (ages 1-4) rate/10K	▲	392.6	569.3	●	429.1
ED Occupational Visits (ages 15-19) rate/10K	▼	101.7	82.1	●	33.0

Obesity (5, 54)

The percent of children who are obese in Essex County continues to climb. All indicators demonstrate a negative trend and are above the NYS benchmark or current upstate NY comparison.

INDICATORS	Essex County Trend	Essex County Previous	Essex County Current	Essex County compared to NYS Benchmark	NYS Bench mark
Public School Children Obese %	▲	19.2	21.4	●	16.7

				Essex County compared to Upstate NYS	Upstate NYS
Elementary Students Obese %	▲	17.7	18.7	●	16.0
Middle/High School Students Obese %	▲	18.9	26.8	●	18.8

Teen Pregnancy (5)

Although the abortion rate for teens in Essex County is lower than previous years and is below the current upstate NY comparison, teen pregnancy and birth rates are both worse than the NYS comparison.

INDICATORS	Essex County Trend	Essex County Previous	Essex County Current	Essex County compared to Upstate NYS	Upstate NY
Pregnancy (ages 15-19) rate/1K females	■	27.0	26.8	●	22.3
Births (ages 15-19)/ rate 1K females	▲	19.4	20.5	●	13.2
Abortions (ages 15-19) rate/1K births	▼	420.3	333.3	●	652.3

Adolescent Alcohol, Nicotine & other Drug Use Behaviors (21)

Vaping use has more than doubled in only two years (from 2016-2018). In 2016 12% of 7th -12th graders reported vaping compared to 25.2% in 2018. This percent also exceeds the *Monitoring the Future Survey (MTF Survey) 2018 [national survey providing a large sample comparison]* of 19.3%. Very small percentages of students reported using inhalants, hallucinogens, methamphetamines, amphetamines, sedatives, tranquilizers, ecstasy, synthetic marijuana, caffeine pills, heroin or other narcotics.

INDICATORS **Last 30 Days Use (Grades 7-12)**	Essex County Trend	Essex County Previous	Essex County Current	Essex County compared to MTF	MTF *
Energy Drinks %	▲	30.2	41.8		N/A
Vaping (E-cigarette) %	▲	12.0	25.2	●	19.3
Cigarette Use %	▼	6.0	3.4	●	4.6
Chewing Tobacco %	▼	5.8	5.0	●	3.4
Marijuana %	▲	12.5	16.9	●	14.6
Alcohol Use %	▲	23.1	25.8	●	18.7

INDICATOR	Essex County Trend	Essex County Previous	Essex County Current	Essex County compared to NYS	NYS Current
Young adults driving while intoxicated arrest rate/10K (28)	▼	96.1	81.7	●	17.5

* MTF =*Monitoring the Future Survey 2018; a national survey providing a large sample comparison*

Adolescent Perceptions about Drug Use (21)

Adolescent perceptions about drug use are mostly trending in the wrong direction and are above (worse) than the national Behavioral Health norm comparison values.

INDICATORS (Grades 7-12)	Essex County Trend	Essex County Previous	Essex County Current	Essex County Compared to BH Norm*	BH Norm*
Perceived availability of drugs in the community %	▼	31.1	30.2	●	28.8
Parent attitudes favor drug use %	▲	34.1	39.4	●	31.3
Peer attitudes favor drug use %	▲	29.7	37.2	●	36.2
Perceived risk of drug use %	▲	57.2	61.0	●	55.2

* BH Norm = Behavioral Health Norm; a national survey providing a large sample comparison

Adolescent Mental Health (5)

The Essex County Mental Health Department identified an increase in requests by local schools for mental health services in schools and resource officers. The rate of children using outpatient mental health services demonstrates an increase from the previous assessment though interpretation of this indicator is complex including variables of need and availability of services. Rates for children served in the ER for mental health and deaths due to suicide are down. (5)

INDICATORS	Essex County Trend	Essex County Previous	Essex County Current	Essex County compared to Upstate NYS	Upstate NYS
Children </=17 served in mental health outpatient setting rate/100K	▼	521.9	1,437.3	●	642.2
Children </=17 served in mental health emergency settings rate/100K	N/A	<10	<10	●	20.0
Death by Suicide (ages 15-19) rate/100K	▼	14.2*	0.0*	●	6.1

▼/● This indicator can be interpreted in different ways given numerous factors, including need and access (availability of services).

* Unstable rate; incidence is less than 10

Adult Physical Health Indicators (5)

Adult obesity continues to be a concern in Essex County affecting over 32% of adults; a rate higher than New York and 9% away from the NYS Prevention Agenda Benchmark. Obesity is a significant risk factor for chronic diseases including diabetes, high blood pressure and cholesterol, heart disease, stroke, asthma, arthritis and certain types of cancer.

With 14.2% having diagnosed diabetes in 2018, Essex County fell within the top 5 counties in NY for prevalence of Diabetes. This is a significant increase from 2015 when the prevalence was only 5.4% and among the lowest 5 counties in NY. Death due to diabetes is also nearly double that of New York.

As depicted below, other select physical health outcome indicators are trending poorly and faring poorly when compared to NY.

INDICATORS (5)	Essex County Trend	Essex County Previous	Essex County Current	Essex County compared to NYS Benchmark	NYS Benchmark
Obesity % (48)	■	32.2	32.2	●	27.4
Heart Attack Hospitalizations rate/10K	▼	14.8	11.9	●	14.0
Asthma ED visit rate/10K	▼	43.7	32.5	●	75.1

				Essex County compared to NYS	NYS
Arthritis %	▲	25.3	29.6	●	21.8
Diagnosed pre-diabetes % (45)	NA	NA	11.5	●	9.9
Diagnosed with diabetes % (45)	NA	NA	14.2	●	10.5

				Essex County compared to Upstate NYS	Upstate NYS
Diabetes deaths/100K	▲	31.6	39.9	●	19.8
Diagnosed with High Blood Pressure %	▲	30.8	37.2	●	33.0
Stroke deaths rate /100K	▲	36.8	40.8	●	38.1
Cardiovascular Disease death rate/100K	▼	320.8	314.1	●	295.7
Diseases of the heart deaths rate/100K	▼	258.3	251.6	●	236.5
Diseases of the heart premature death (35-64) rate/100K	▼	115.3	84.2	●	82.8
Chronic lower respiratory disease deaths rate/100K	▲	56.5	72.0	●	45.4
Lung and Bronchitis Cancer Cases rate/100K	▲	112.2	114	●	84.3
Lip, Oral Cavity & Pharynx Cancer Cases rate/100K	▲	17.9	19.9	●	14.7
Asthma %	▲	9.6	12.4	●	10.1
Prostate Cancer Cases rate/100K	▼	155.9	116.3	●	151.7

Screenings (5)

Screening rates for select chronic diseases are all lower than NYS comparisons/benchmarks.

INDICATORS	Essex County Trend	Essex County Previous	Essex County Current	Essex County compared to NYS	NYS
Diabetes & Pre-diabetes Testing %	▲	49.2	53.6	●	57.9
Cholesterol Check %	▼	78.2	70.0	●	84.2

	Essex County Trend	Essex County Previous	Essex County Current	Essex County compared to NYS Benchmark	NYS Bench mark
Colorectal screening as recommended %	▼	68.3	66.9	●	80.0

Behaviors (40)

With the exception of smoking, health behavior indicators are all faring better than NYS comparisons.

INDICATORS	Essex County Trend	Essex County Previous	Essex County Current	Essex County compared to NYS Benchmark	NYS Benchmark
Smokers % (48)	▲	16.6	16.8	●	12.3

				Essex County compared to NYS	NYS
Vapers (e-cigarette Users) %	NA	NA	Suppressed (small sample size)	NA	4.3
Leisure Time Physical Activity %	▼	76.2	75.6	●	74.0
Consuming No Fruits or Vegetables %	NA	NA	17.3	●	31.5
Consuming Sugar Sweetened Beverages %	▼	26.8	23.4	●	24.2
Chronic Disease Self-Management %	▲	4.9	9.9	●	9.5

Social/Emotional/Mental Health & Substance Use

The mental health/substance use data paints a mixed picture in Essex County. Residents report more poor mental health days and more binge drinking; however, suicide deaths and alcohol related car crashes are down. Opioid and substance use data are also mixed, with ED visits involving any drug trending higher than in other North Country counties, but overdose death rates showing improvement.

INDICATORS (4,47)	Essex County Trend	Essex County Previous	Essex County Current	Essex County compared to NYS Benchmark	NYS Benchmark
Poor mental health days (14+/month) %	▲	11.3	14.4	●	10.1
Death by suicide rate/100K	▼	14.8	12.9	●	5.9
Binge drinking in the last month %	▲	21.9	24.7	●	18.4

	Essex County Trend	Essex County Previous	Essex County Current	Essex County compared to Upstate NYS	Upstate NYS
Alcohol-related Crashes rate/100K	▼	102.6	94.8	●	53.2
Alcohol-Related Injuries & Deaths rate/100K	▼	54.7	31.6	●	10.5

	Essex County Trend	Essex County Previous	Essex County Current	Essex County compared to NYS	NYS
Opioid burden (ED Visits, discharges, dependence, deaths)	Not comparable	N/A	123.4	●	295.9
ED visits involving any drug/100K (18-24 year olds)	Not comparable	N/A	453.0	●	272.2
Overdose deaths any opioid rate/100K*	▼	18.2	10.5	●	15.5
Overdose deaths any drug rate/100K*	▼	20.8	18.4	●	18.9

* Unstable rate; incidence is less than 10

Older Adults (65+) (5)

Health indicators for older adults show positive movement in all categories except for flu shot uptake and asthma ED visit rates.

INDICATORS	Essex County Trend	Essex County Previous	Essex County Current	Essex County compared to NYS Benchmark	NYS Benchmark
Flu shot received in the last year %	▼	68.3	57.8	●	70.0
Fall hospitalizations rate/10K	▼	110.9	110.3	●	204.6

				Essex County compared to Upstate NYS	Upstate NYS
Served in Out Patient setting for mental health (ages 65+) rate/100K	▼	88.0	62.5	●	170.3
Served in ED setting for mental health (ages 65+) rate/100K	*	*	*	Not comparable	5.7
Pneumonia shot received in the last year %	▲	59.3	73.7	●	73.8
Flu/Pneumonia hospitalizations rate/10K	▼	133.7	98.4	●	93.7
Asthma ED Visits rate/10K	▲	15.9	26.9	●	19.1
Unintentional Injury Hospitalizations rate/100K	▼	198.6	142.3	●	239.3

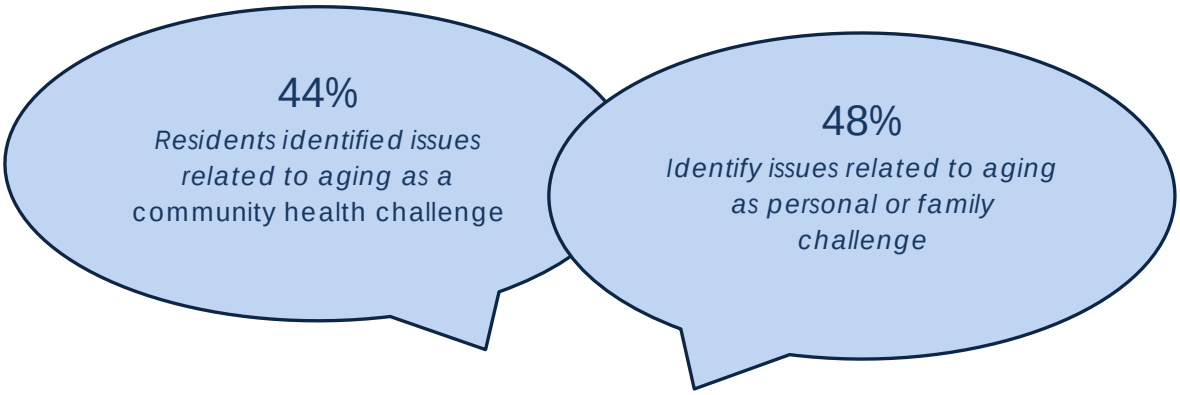
▼/● This indicator can be interpreted in different ways given numerous factors, including need and access (availability of services).

* Unstable rate; incidence is less than 10

Alzheimer's disease and other dementias pose significant quality of life health concerns for patients, caregivers and families. This health condition as a national cause of death increased 145% from 2000-2017 and is projected to increase 15% more from 2018-2025. It is currently the 6th leading cause of death in the United States with an estimated that 1 of every 3 seniors dying with Alzheimer's or other dementia. (6)

Alzheimer's data does not currently appear as a leading cause of death in Essex County or NY. However, given the high percent of residents aged 65 years or older in Essex County it is reasonable to expect that Alzheimer's disease and other dementias will be of increasing concern for Essex County residents.

Residents identified issues related to aging as a concern for their community and themselves.



The Essex County Office for the Aging (OFA) provide services to community members through several programs and services. Notable in their data is that many clients participating in their services have multiple chronic conditions. The percent of clients with chronic conditions varies by the type of service. (68)

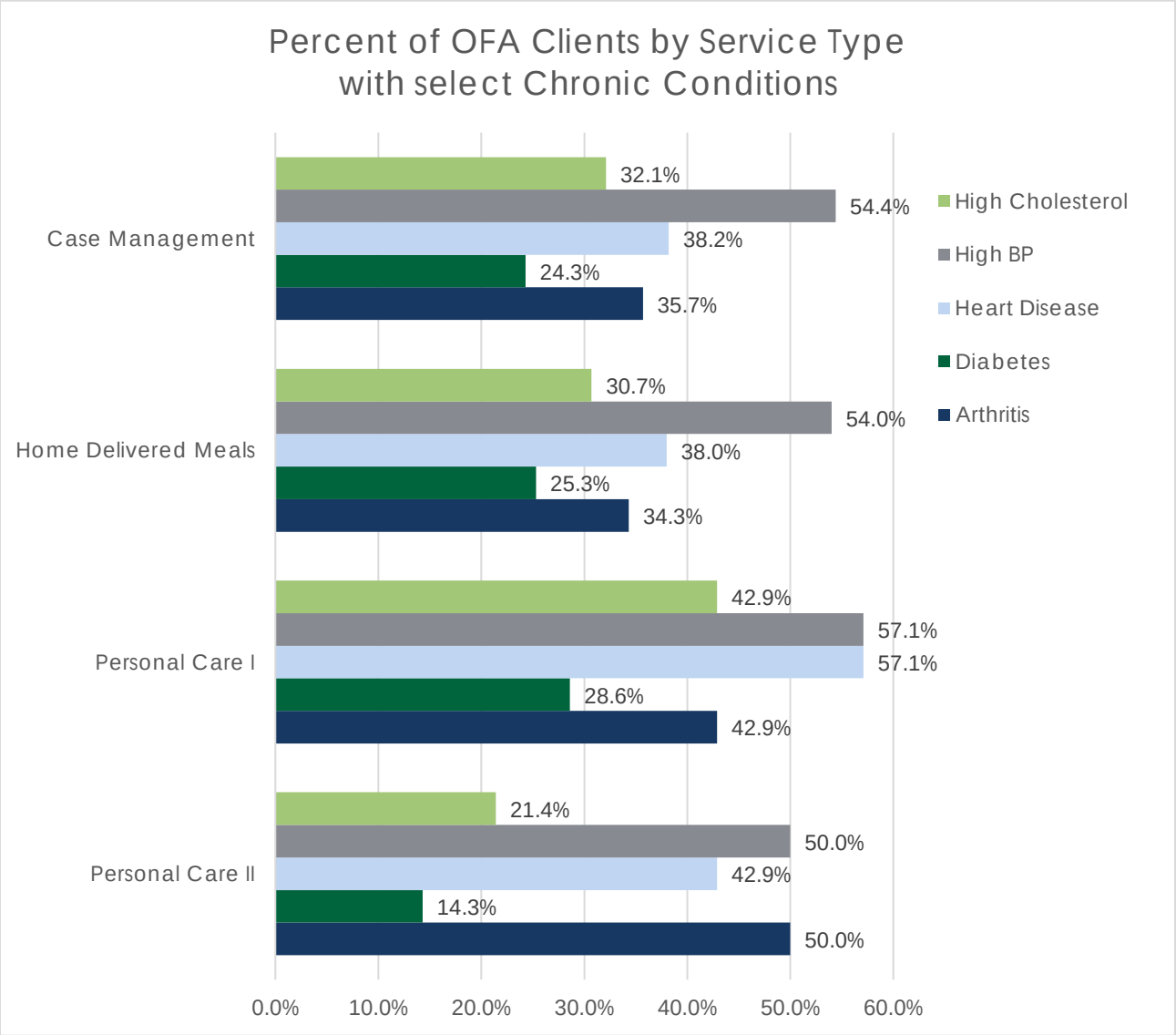
There are 4 major categories of service for OFA clients. They are:

Case Management	= in-depth care planning with staff to ensure client accesses all services needed; assistance with referrals, paperwork completion; etc.
Home Delivered Meals	= receipt of "Meals on Wheels" program
Personal Care I	= non-hands on assistance (light house-keeping, shopping assistance, laundry, meals, phone, etc.)
Personal II	= hand-on assistance (bathing, hygiene, dressing, feeding)

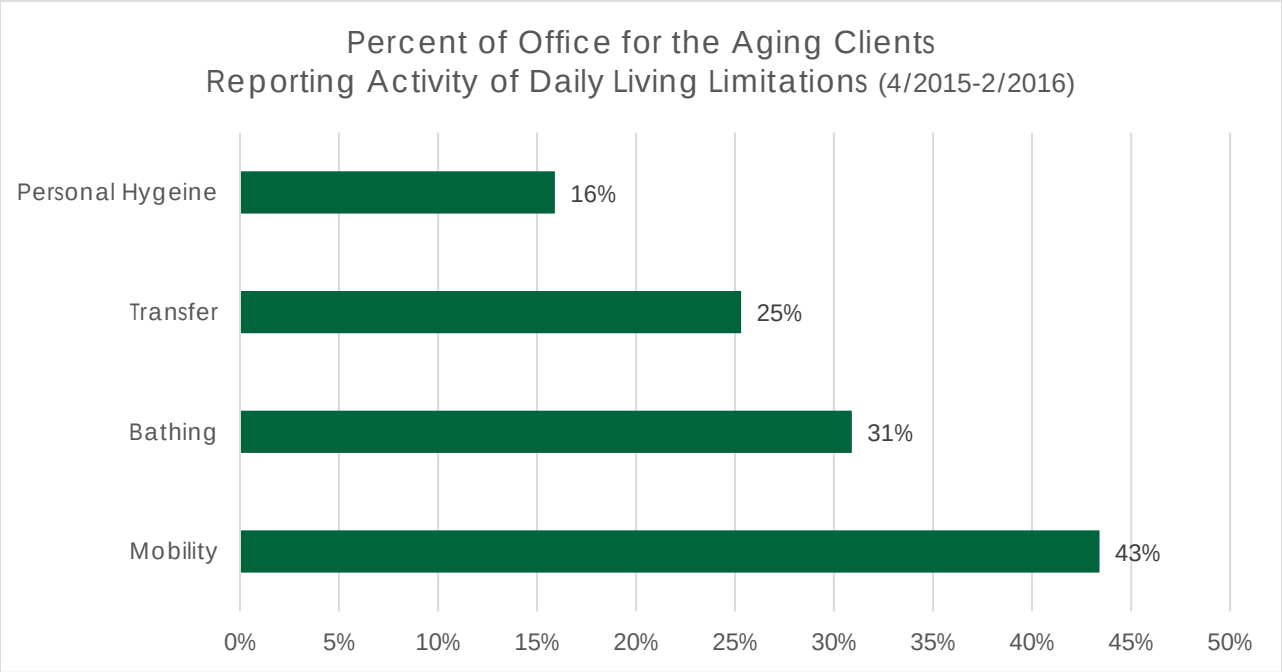
Conditions most commonly identified by OFA clients are:

- High cholesterol,
- High blood pressure,
- Heart disease,
- Diabetes and
- Arthritis

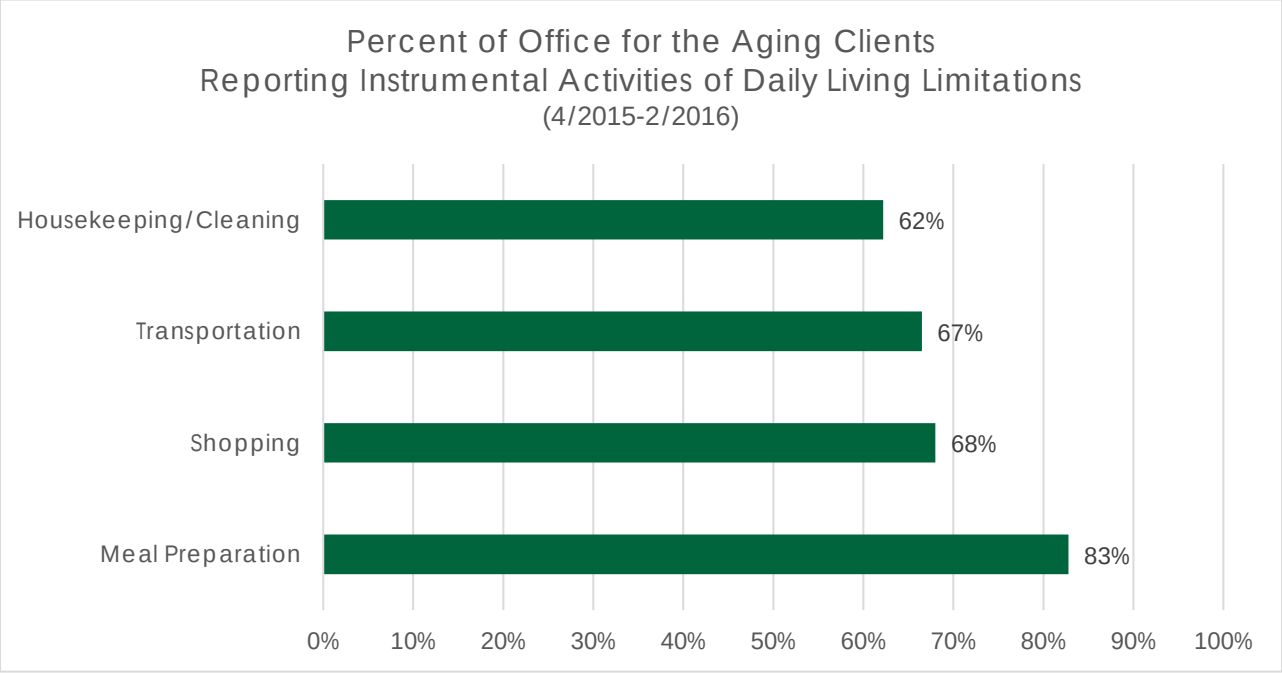
The chart below provides a snapshot of conditions where 25% or more of clients within 3 of the 4 major categories of services have diagnosed conditions. (68)



Of daily living limitations reported by Office for the Aging clients, Mobility (43%) is the highest. (68)



Over 50% of clients report limitations in instrumental activities of daily living including meal preparation, shopping, transportation, housekeeping/cleaning. (68)



"There should be community vans or other means of transportation for the elderly who aren't driving."

Evolving Topics in Health

Downward pressures inside and outside the healthcare delivery environment can create intended and unintended health consequences (both good and bad) for the populations impacted by these forces.

This section examines three evolving topics that have either already influenced health outcomes – or that have the potential to influence health outcomes – in Essex County:

- The Changing Health Care Environment;
- Climate and Health; and
- Legislative Updates.

The Changing Health Care Environment

Advances in Technology

The rise of telehealth services may be able to address the lack of providers, particularly specialists, in Essex County. As access to specialists and acute care services is more readily available outside of the county within an hour drive, many residents of Essex County must travel for care.

Telehealth services in Essex County, such as remote-monitoring and distant site visits, could help increase access to care for certain specialty services without having the need for residents to travel. A relaxation in regulations governing the 'originating site' for a virtual visit, as well as investment in broadband technology, can help address access to care for those in rural areas such as Essex County. Remote monitoring (where a patient has a wearable device that relays clinical information back to a health care provider) can also help healthcare providers triage those patients who are in greatest need.

Such technology use is beginning in Essex County such as through the Health Department Home Health Unit home visiting program. Expansion of telehealth across the healthcare sector is anticipated to improve access to care and health outcomes for residents.

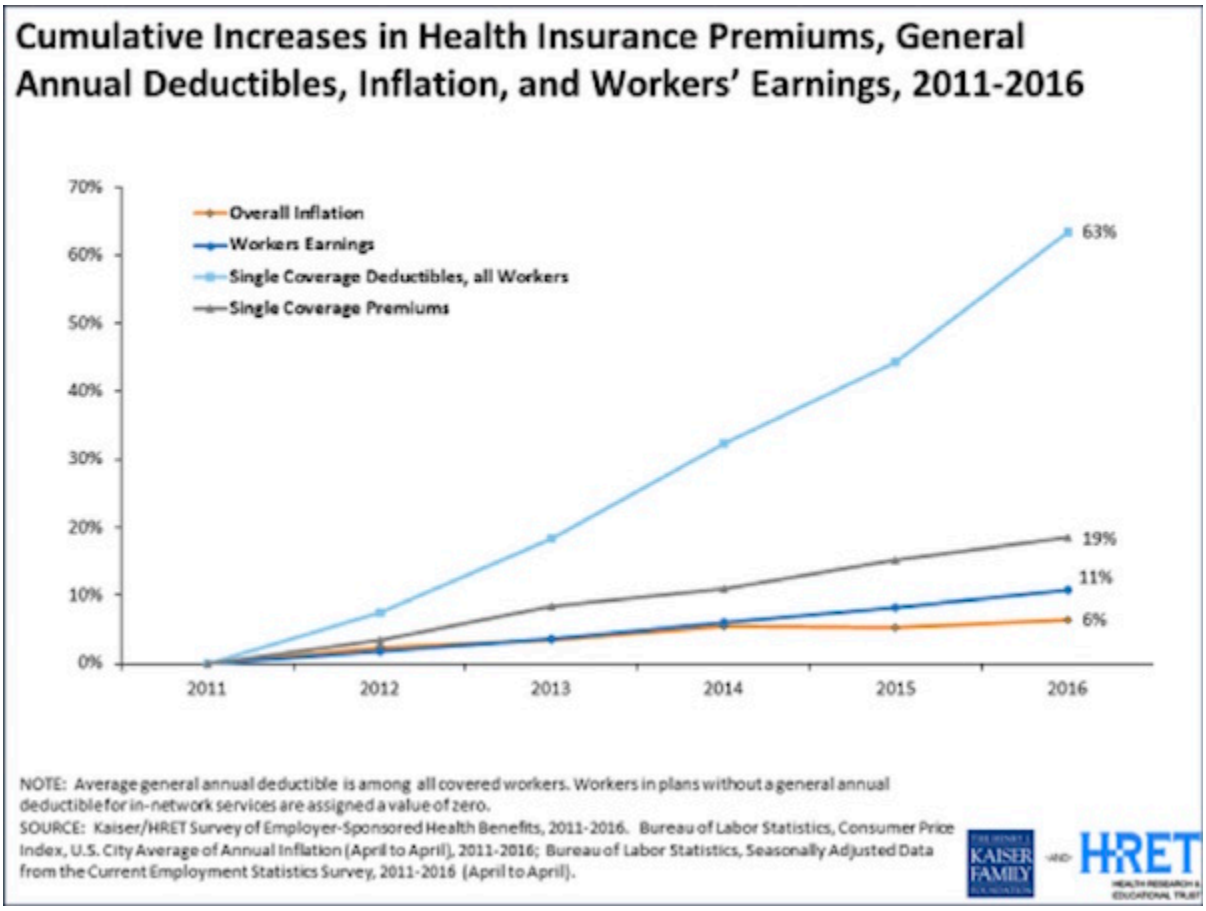
Care Coordination

As the provider shortages in rural America continue to impact access to care, a whole-person care model continues to evolve that functions in large part through 'care coordination' provided by healthcare providers. By 2007, a patient-centered medical home model was established with a core element of coordinating care across many elements of the healthcare system. Today, the limited number of providers are supported in their care of patients by a team of nurses, health educators, nutritionists and other health professionals in the care of a patient whether it is in primary care, behavioral health or in an inpatient setting.

The previously mentioned 'remote monitoring' and other technological advances will assist in this new model of care by automating processes for delivering patient care. The future of primary care will be built upon this patient-centered, whole person care system that will be enabled by networked care coordinators working at the direction of physicians and mid-levels.

Cost of Care

The year-over-year increase in the cost of healthcare continues to outpace the rate of inflation and workers earnings nation-wide; see the figure below. (70)

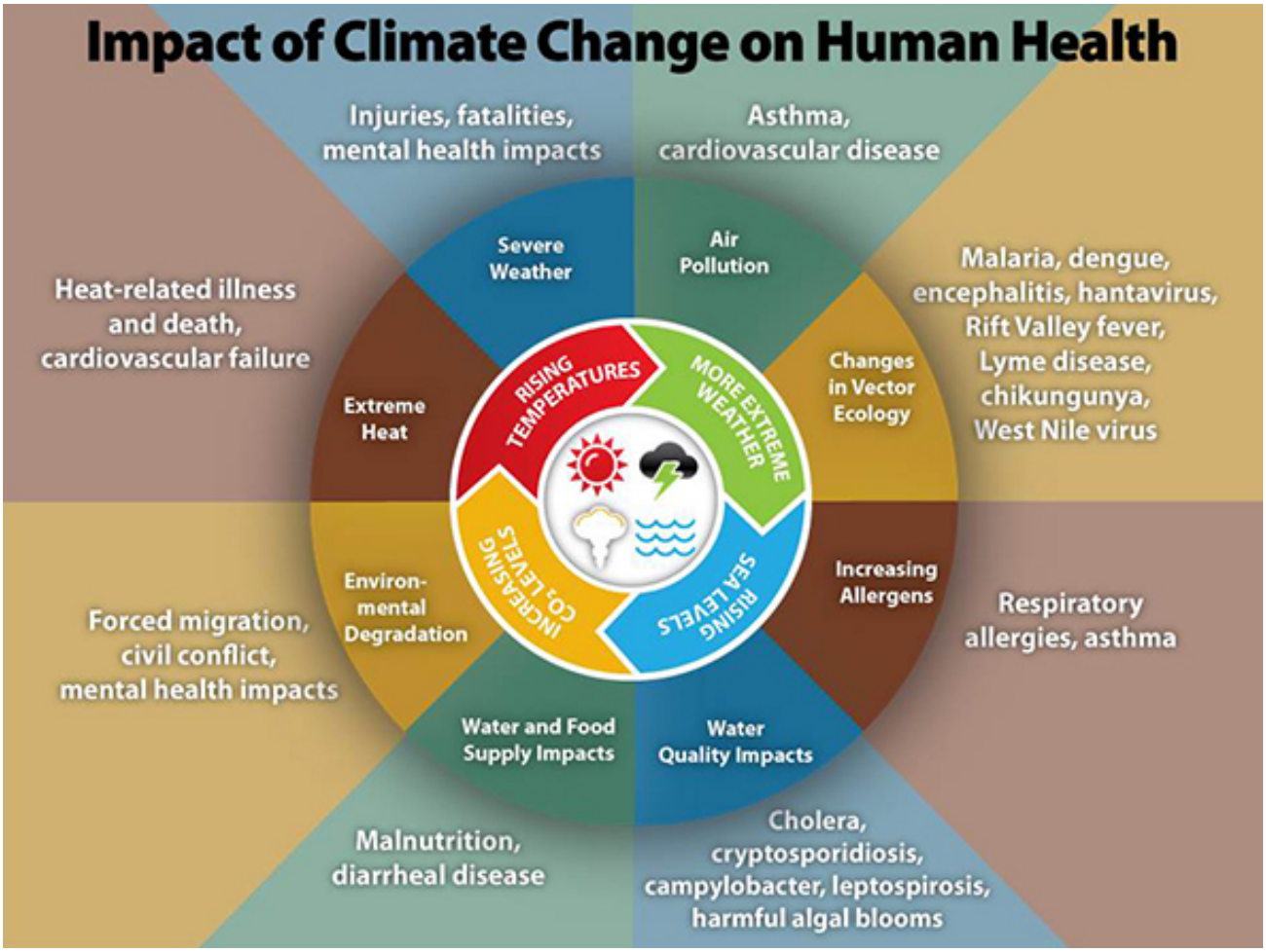


In the North Country, an effort is underway by a consortium or healthcare organizations to put patients at the center of care to improve care outcomes through alignment, integration and coordination for the region. The North Country Innovation Pilot (NCIP) aims to have these organizations collaborate rather than compete in the care of North Country residents such as the population of Essex County. Two of the NCIP organizations (Adirondack Health and the University of Vermont Health Network) have facilities in Essex County.

Among the areas of opportunity to improve patient outcomes for the NCIP are preventable complications, reduce the increase in cost for care (bend the cost curve), diagnostic intensity, treatment selection and site of care. Collaboration, quality outcomes and care coordination will be essential in the endeavor to maintain health care costs at a more sustainable rate while improving the health of the population in the North Country.

Climate and Health (10)

Climate change has been a hot topic nationally and whether naturally occurring and/or man-made, climate change has human health implications. The Centers for Disease Control and Prevention provide a visual aid to demonstrate these implications. This report highlights three locally experiences of climate change: Severe Weather; Water Quality Impacts; and Changes in Vector Ecology. This is included in the Climate & Health category of Section 2.



Legislative Updates

Legislative updates – at national, state and local levels – have the ability to impact health of Essex County residents. Here, several state-wide legislative initiatives are identified that stand to have a significant impact on public health practice and outcomes. These are:

- Removal of non-medical exemptions from school vaccination;
- Lead Poisoning Prevention Mandate (lowering actionable elevated blood lead level from 10 mcg/dL to 5 mcg/dL);
- Update of the Adolescent Tobacco Use Prevention Act (ATUPA) increasing the minimal legal sale age of tobacco and e-cigarettes from 18 to 21 years;
- Temporary ban on flavored e-cigarette liquids;
- Package of bills to help address the heroin and opioid epidemic, as well as prescription drug abuse[5].

The analysis of legislative updates is an area identified by ***Essex County Health Partners*** for future further investigation and inclusion in the CHA.

This concludes Section 1 of this Community Health Assessment; the analysis of health data, the clinical information and incidence of specific health behaviors, as often associated with health.

SECTION 2: SOCIAL DETERMINANTS OF HEALTH

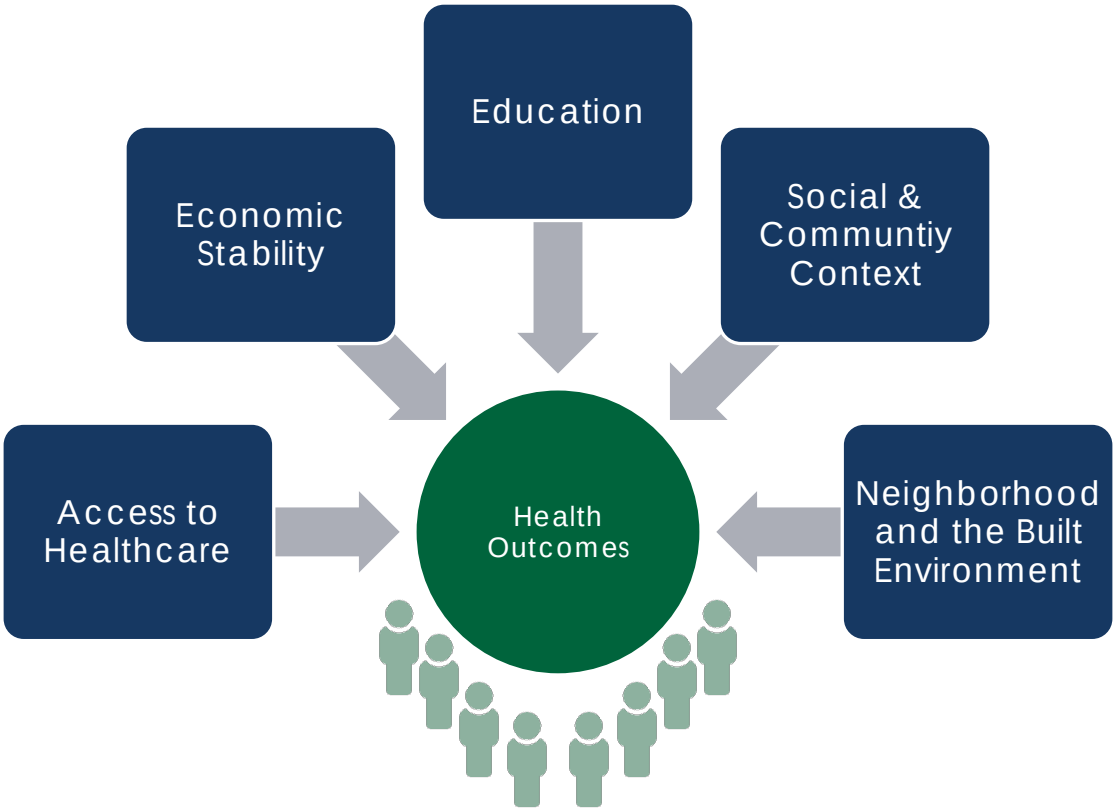
Section 2 examines the other factors – healthcare landscape, employment, income, housing, water quality, etc. – known to be a greater predictor of the health and well-being of a community overall.

The phrase Social Determinants of Health describes the complex environment in which people live that influences their health. It includes "places" such as neighborhood, school and work as well as "conditions" including social engagement, sense of security, economic stability and access to health promoting opportunities or care services.

Section 2 follows the Healthy People 2020 organization of social determinants into five domains (27):

- Access to Health Care
- Economic Stability
- Education
- Social & Community Context
- Neighborhood and the Built Environment

This assessment explores the places and conditions of Essex County that influence health outcomes of residents. The WHY IT MATTERS description is continued in this section to help readers understand how these key areas influence health outcomes and that inequities in these areas lead to disparities in health outcomes.



Community Engagement Initiatives

The three local community engagement activities: the Stakeholder Survey, Distributed Focus Group and Community Survey provide perceptions of what people experience and believe. As data in the domains of social determinants of health are explored, the reader can follow how perceptions and realities align. (17)

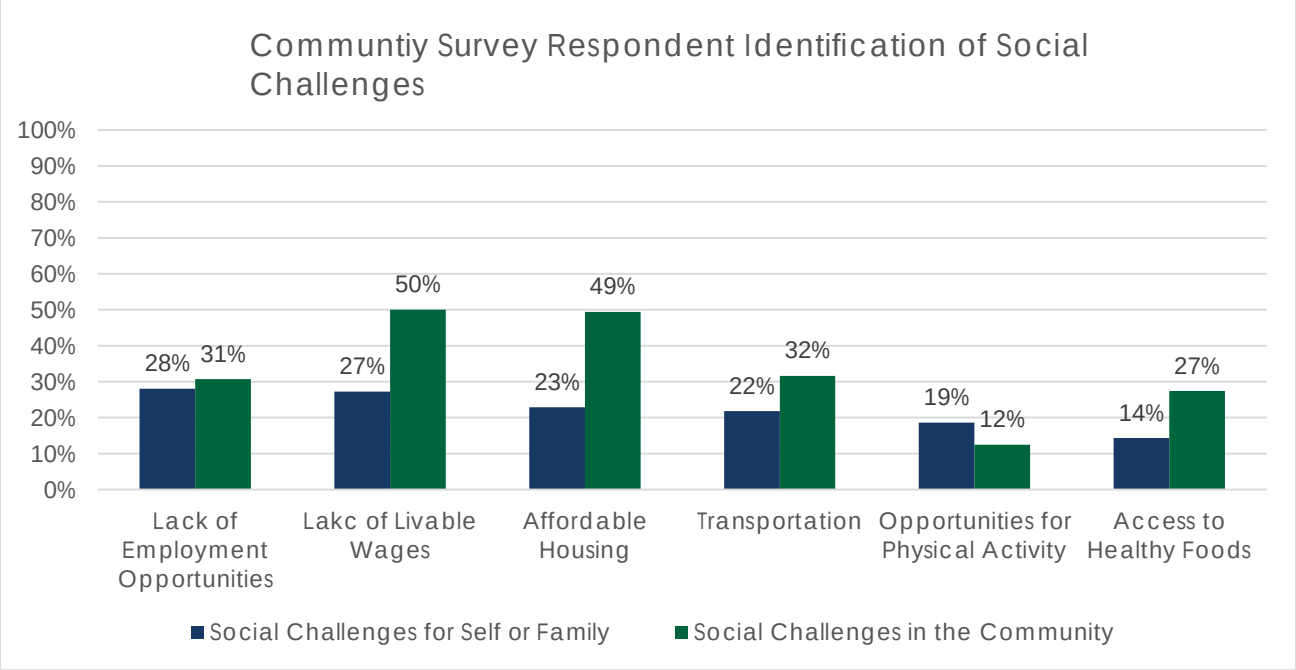
Community Perceptions

Residents were asked to identify social challenges experienced by themselves or family members as well as within their community. Most frequently identified in both of these categories (self/family or community) were:

- lack of employment opportunities,
- lack of livable wages,
- affordable housing, and
- transportation.

The 5th most frequently identified challenge was:

- Access to Healthy Foods within the community and
- Opportunities for Physical Activity for respondents and their families.

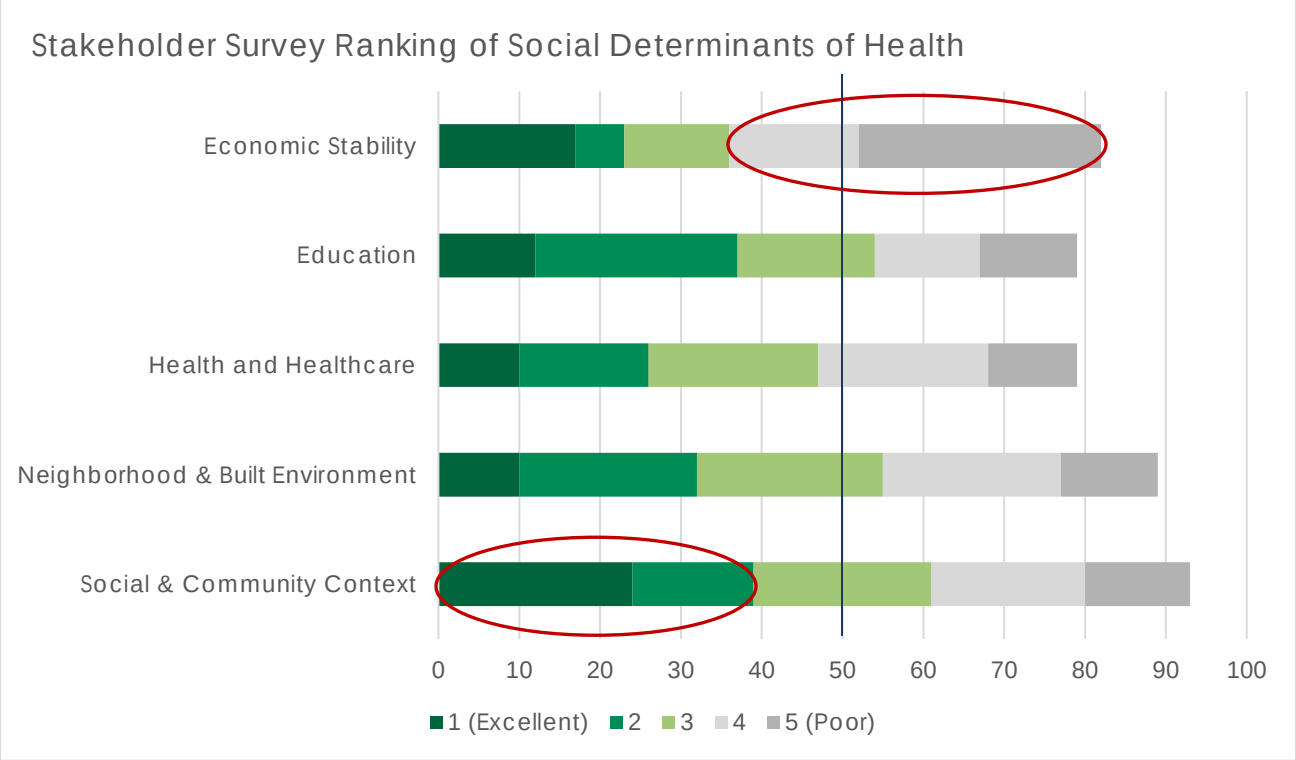


Stakeholder Perceptions

The Stakeholder Survey asked participants to rank how they perceived the 5 domains of social determinants of health to be impacting residents on a scale of order of 1-5 where (1) excellent" means that domain is positively impacting residents and (5)"very poor" means that domain is negatively impacting residents.

Notable results of this survey indicate:

- Economic Stability was largely identified as negatively impacting residents (4 or 5);
- Social and Community Context was identified as positively impacting residents (1 or 2).



The Distributed Focus Group Initiative asked *"If you could change 1 thing about your community to make it better, what would it be?"* This word cloud visual display shows the larger the word/phrase, the more times this was identified by respondents.

Healthcare System Overview

This section provides a brief description of the healthcare system in Essex County, along with challenges and comparisons to benchmark data. As noted in the next section, the existing health system is the viable design when considering population and geography.

Healthcare System Profile (5)

1	Hospital
25	Beds
3	Nursing Homes
340	Beds
4	Adult Care Facilities
194	Beds
3	Nursing Homes
340	Beds
11	Health Centers
3	Emergency Services Sites
1	Urgent Care Site

*Health Professional Shortage Areas** (25)

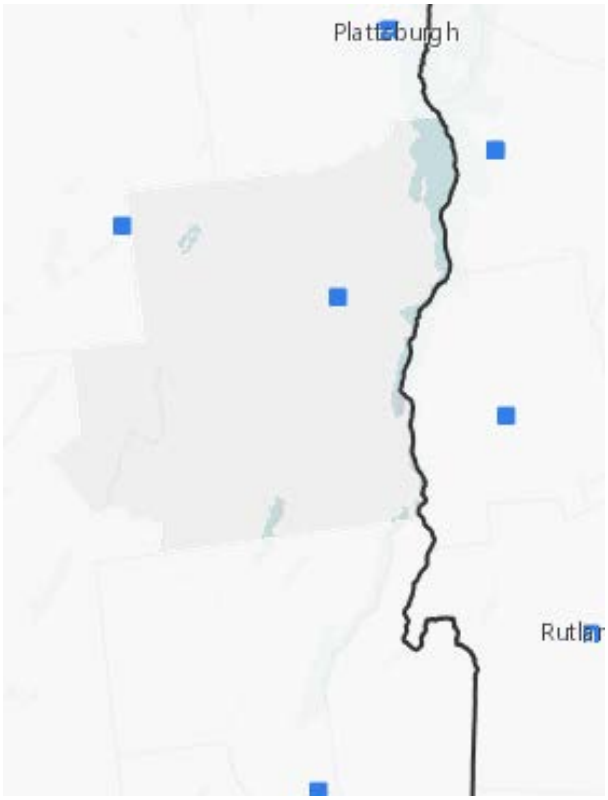
8	Primary Care	Geographic
3	Dental Care	Medicaid-eligible
3	Mental Health	Geographic

* There are 6 categories of Health Professional Shortage Areas (HPSA) designations.

Shortages in Essex County are related to:

- **geography** - a shortage of providers within a defined geographic region; and
- **population** – a shortage of providers for a specific sub-population (Medicaid-eligible) within a defined geographic region.

Locations of Hospitals (8)



Regular Provider		*Benchmark*
89%	Adults (18+)	91%

*Emergency Visit Rate**		*Benchmark*
4,912	Essex	3,866 Upstate NY

* Rate is per 10,000, demonstrates an increase since the previous assessment and is higher than the Upstate NY rate. (5)

The following portions of this section address the social determinants of health in greater detail as they pertain to Essex County residents. The main categories that will be explored are the 5 Healthy People 2020 domains cited earlier: Access to Healthcare Barriers, Social & Community Context, Education, Neighborhood & Built Environment, and Economic Stability.

Access to Healthcare

WHY IT MATTERS

Access to healthcare means timely use of care to achieve the best possible personal health outcomes. Healthcare includes all aspects of the care system including, and not limited to, primary care, specialty care, emergency transportation and services, rehabilitative and long term care, beyond physical health and includes behavioral and mental health. (27)

Barriers to accessing the healthcare system can be categorized as:

- **Financial -**lack of insurance or ability to pay for care;
- **Provider Shortages** -inadequate providers for the population;
- **Geographic** -physically inaccessible care within a region or necessary to go far for care;
- **Transportation** -un-available, un-accessible, un-reliable or un-affordable; and
- **Social or cultural** -differences in social practices or acceptances, languages or health literacy.

IN ESSEX COUNTY

The top 3 barriers to care in Essex County are Geography, Provider Shortages & Transportation.

GEOGRAPHY

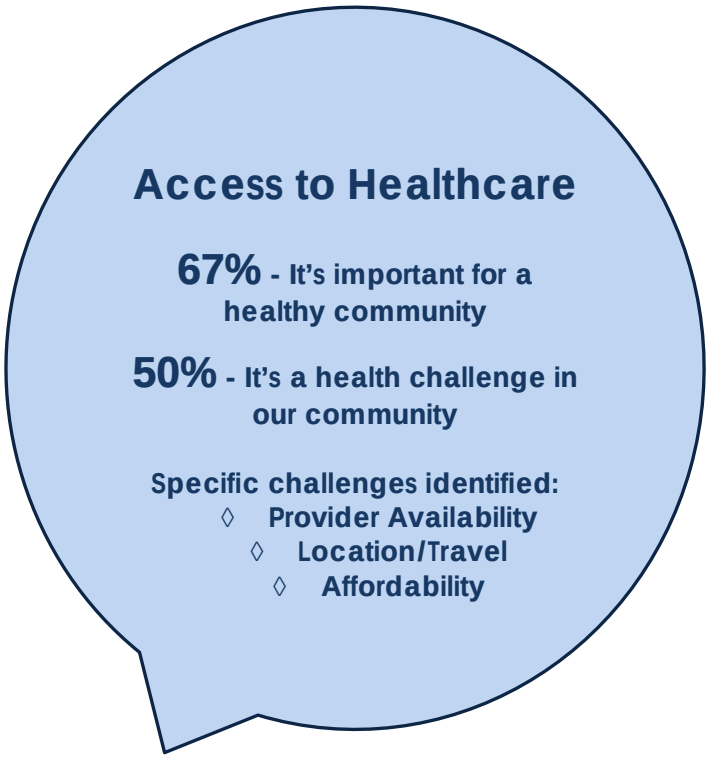
The rural nature of Essex County and small population has led to the existing healthcare system.

There are 11 community health centers throughout Essex County providing good geographical access to Primary Care.

Emergency Care is also accessible with 3 locations and 1 Urgent Care location.

There is one critical access hospital in Essex County located in the county seat, Elizabethtown.

Acute and specialty care facilities are located in the surrounding region in all directions allowing most residents to access care within an approximate 1 hour drive from any location in the county.



Provider Shortages

Community Survey respondents identified long waits for appointments and brief or rushed healthcare visits as healthcare access challenges. Health Professional Shortage Areas data and patients to provider ratios agree with resident experiences of provider shortages with Primary Health, Mental Health and Dental Health ratios all considerably worse than the NYS average.

The relatively small population in Essex County equates to a patient volume problem for acute and specialty care providers and services being more accessible. However, larger health care institutions are within an hour drive from most residents of the county. Albeit challenging for rural and aging residents, the existing system and geographic layout is the viable design.

Telemedicine services is a growing area in healthcare. Between 2006 and 2016 the utilization of Medicare distant site telehealth visits grew nearly 16 times (.6 to 9.5 per 1,000 encounters). (59)

Telehealth services in Essex County, such as remote-monitoring and distant site visits, could help increase access to care for certain specialty services without requiring residents to travel. (59)

Primary Care Provider Ratio

2,540:1	Essex
1,200:1	NY
1,050:1	Top Performers (90th Percentile)

The Patient to Primary Care Provider Ratio in Essex County is more than double that of the NY average and fairs worse than US Top Performers. (58)

Mental Health Provider Ratio

720:1	Essex
370:1	NY
310:1	Top Performers (90th Percentile)

The ratio of patients to mental health providers is also considerably higher in Essex County than the NY average; nearly double, and fairs worse than US Top Performers. (58)

Dental Health Provider Ratio

3,160:1	Essex
1,230:1	NY
1,260:1	Top Performers (90th Percentile)

While NY as a whole meet Top Performer standards, this is not so in Essex County where the ratio of patients to dentists is more than 2.5 times the NY average. (58)

TRANSPORTATION (5)

40% Households with 0-1 vehicle

Described more completely under the Transportation section of this report and related to other socio-demographic and economic factors, the following transportation barriers exist for Essex County residents:

- Vehicle access/availability
- Limited public transportation
- High costs for leasing/owning
- Long distances/travel time
- Aging population with driving limitations.

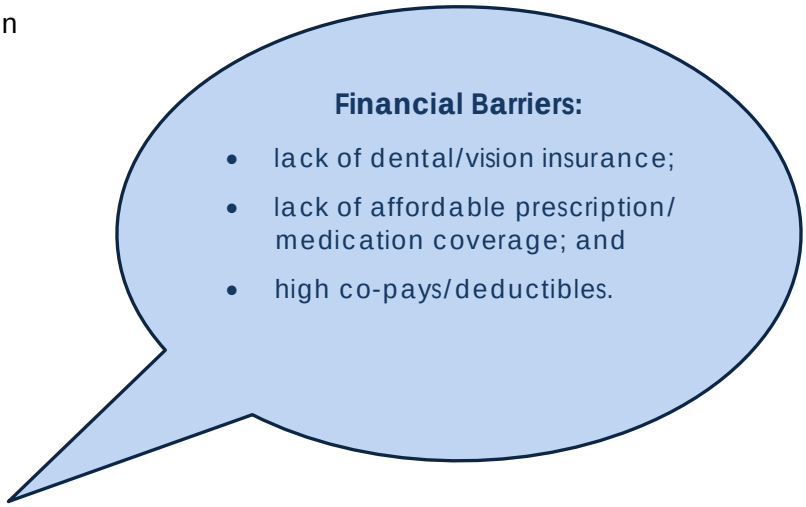
Financial

More Essex County residents are covered by health insurance than ever before and a smaller percent of residents report not receiving care due to costs here than in NY. (5)

Insurance Coverage		Benchmark
97%	Children	100%
95%	Women	100%
94%	Adults (18-64)	100%

Didn't Receive Care Due to Cost			
7%	Essex	11%	NY

However, residents express financial barriers to healthcare.



Socio-Cultural

The need to ensure socio-cultural appreciation within the healthcare system, throughout community based organizations, our schools, communities and media continues to grow. As demonstrated in this assessment, the Essex County community continues to diversify in race, language, religion and sexual identity. Health disparities often exist within such sub-populations who experience barriers to preventive and restorative health care. (59)

Essex County Health Partners and scores of community based organizations and stakeholders have participated in cultural competency and health literacy trainings provided by the Adirondack Health Institute since 2016. Such opportunities have served to reduce socio-cultural barriers to healthcare by improving:

- the behaviors, attitudes and policies of agencies and systems allows for sensitive and effective service of all types of individuals with respect, empathy and dignity regardless of socio-cultural differences (cultural competency) and
- the ability of patients to obtain, process and understand health information (health literacy). (3)

Social and Community Context

WHY IT MATTERS (27)

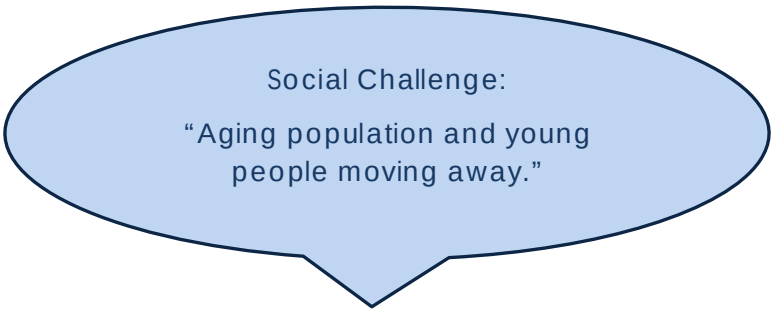
Health behaviors and outcomes along with needed services and healthcare utilization are all influenced by the composition of people within the community.

Analysis of demographic information and other social determinants of health help predict and plan for community needs. Factors include:

* age
* people living with disabilities
* veteran status
* ethnicity
* migration
* language spoken at home
* religious groups
* gender and sexual identity

And beyond including:

* Civic participation
* Discrimination
* Incarceration



Age

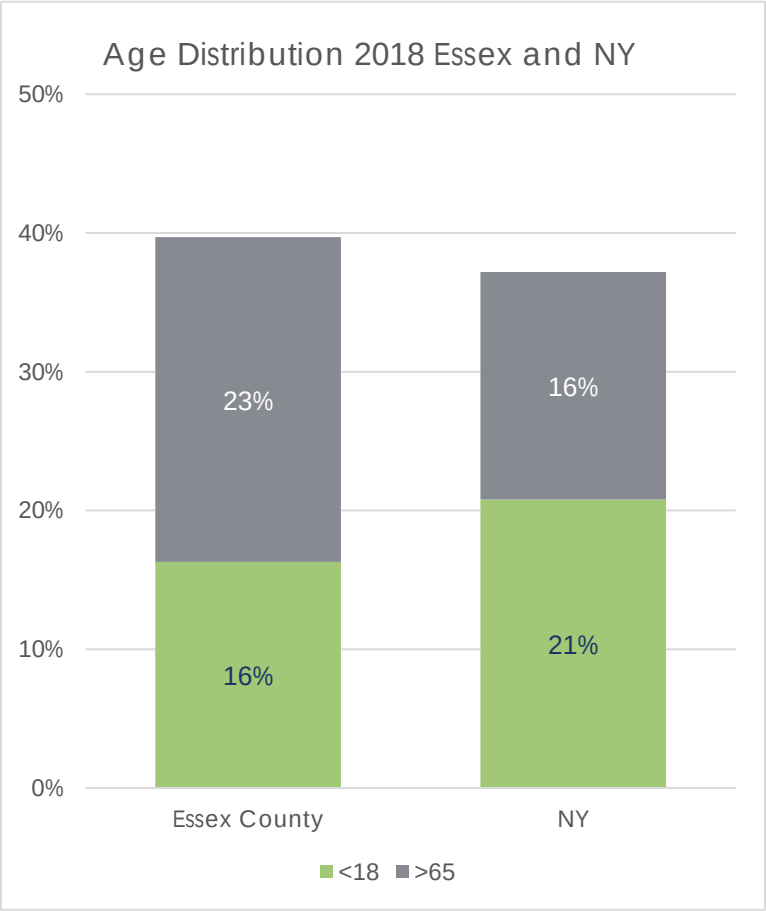
WHY IT MATTERS

It is estimated that over 60% of aging adults manage two or more chronic conditions. Such health often leads to reduced quality of life and life expectancy. (27)

IN ESSEX COUNTY

One of the most distinguishing characteristics of Essex County demographics is age. The distribution of those under 18 and older than 65 is inverted in Essex County compared to NY and the US. (5)

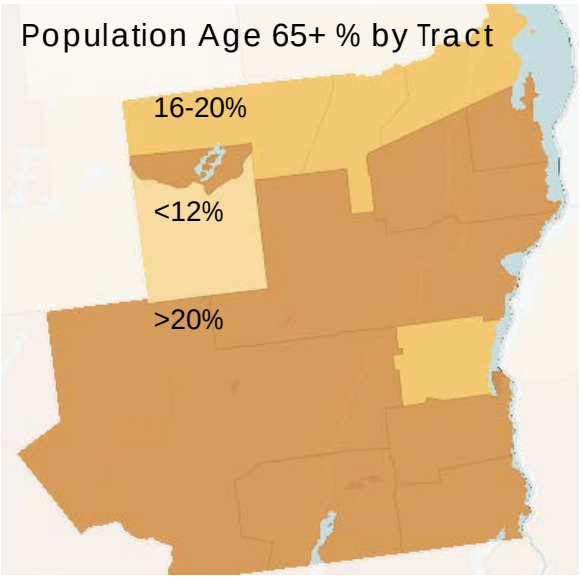
It follows that issues related to aging may impact a larger percent of the whole population in Essex County than may be found throughout the state. This includes chronic conditions often associated with aging and living with one or more disabilities.



Over 20% of the population is 65+ in almost all communities in the county. (8)

With the exception of Moriah, these communities are closer to social and economic hubs of Plattsburgh (north) and Saranac Lake (west).

The Town of North Elba has the smallest percent (under 12.1%)



People Living with Disabilities

WHY IT MATTERS (10, 27)

Our environment, culture and society often include barriers for people with disabilities in experiencing a full range of life activities. This results in higher rates of chronic conditions including obesity, diabetes and heart disease.

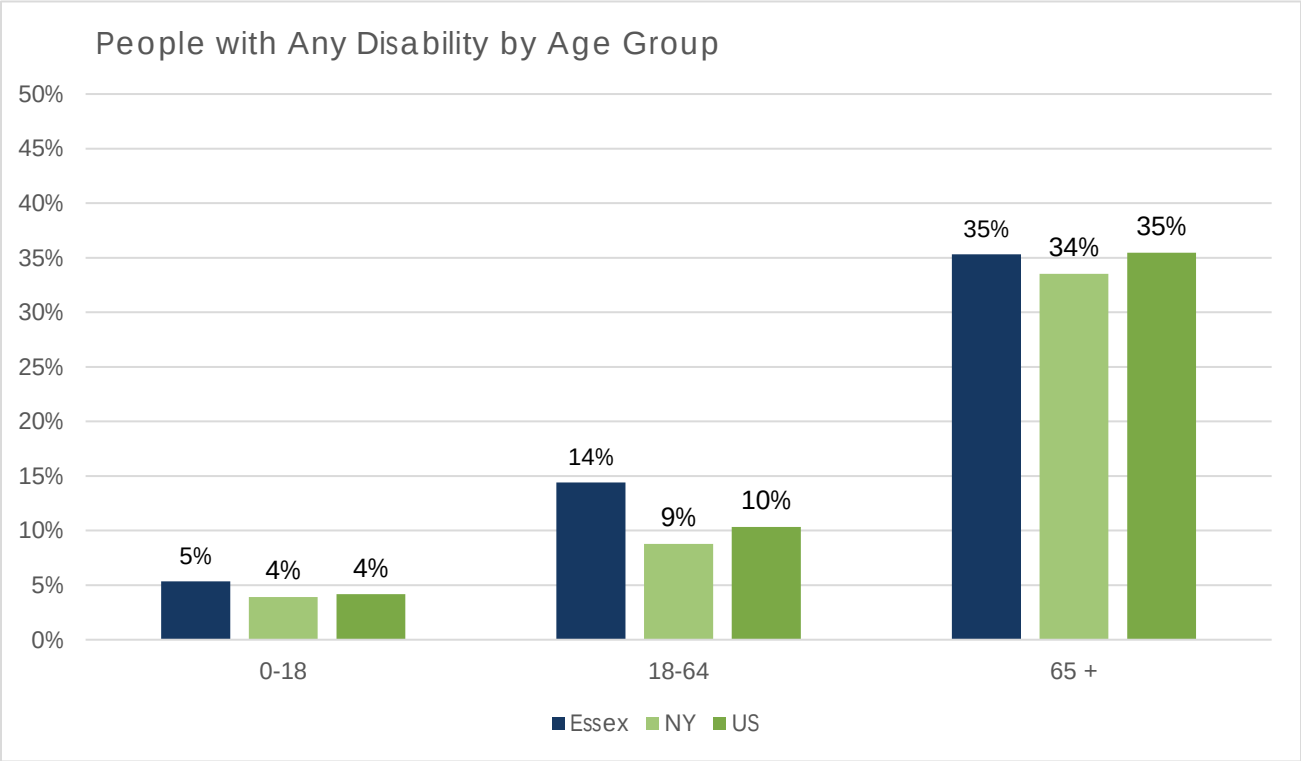
Interventions that remove barriers create accessible environments, and support policies and systems changes that benefit people with disabilities will help reduce disparities in health outcomes for people with disabilities.

IN ESSEX COUNTY

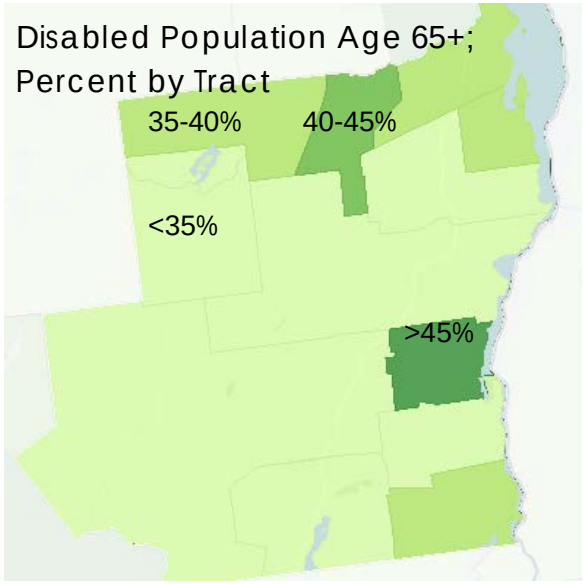
More of the population in Essex County (27%) report living with a disability compared to NY (23%). Effecting more than 10% of the population are mobility (16%) and cognitive (11%) disabilities. (5)

People with Disabilities, % by Type	Essex	NY
People with a disability	27%	23%
Mobility Disability	16%	13%
Cognitive disability	11%	9%
Hearing disability	8%	4%
Independent Living Disability	7%	4%
Vision disability	4%	4%
Self-Care Disability	3%	4%

Analysis of disabilities across the lifespan demonstrate an increase in the percent of the Essex County population living with a disability with the highest percent in the age range of 65+. This general trend is consistent when compared to NY and the US. It is notable that the percent of people living with disabilities in the age range of 18-64 (14%) is 5 percentage points higher than the NY 10%. (8)

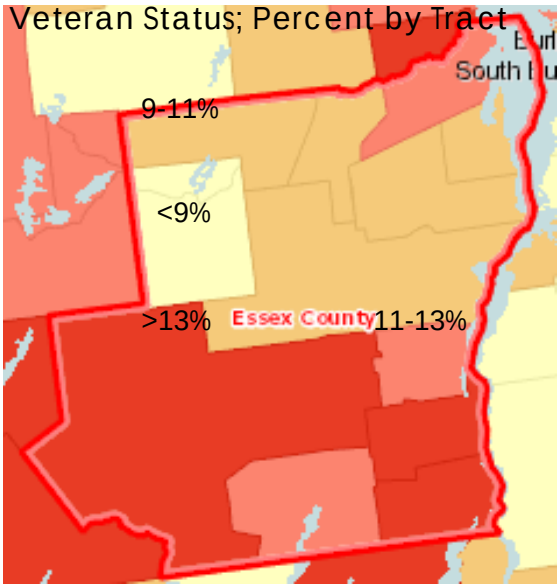


In examining geographic distribution of the disabled population ages 65+ reveals the highest percent on the Town of Moriah (>45%) followed by the Town of Jay (40—45%). (8)



Veteran Status (8)

10% Essex County
5% NY



WHY IT MATTERS

Veteran status often reflects positively on the overall wellbeing of service members. However the type of service, duration, duties and experiences can also negatively impact service members' physical, mental and social wellbeing. (31)

IN ESSEX COUNTY

An average of 10% of the population are veterans; double the NY average.

Higher than 13% of many communities in the southern portion of the county as depicted in the map (right). (8)

Race and Migration

WHY IT MATTERS

People in minorities and migrants often experience disproportionate burdens of preventive disease, disability and death than non-minorities. (27)

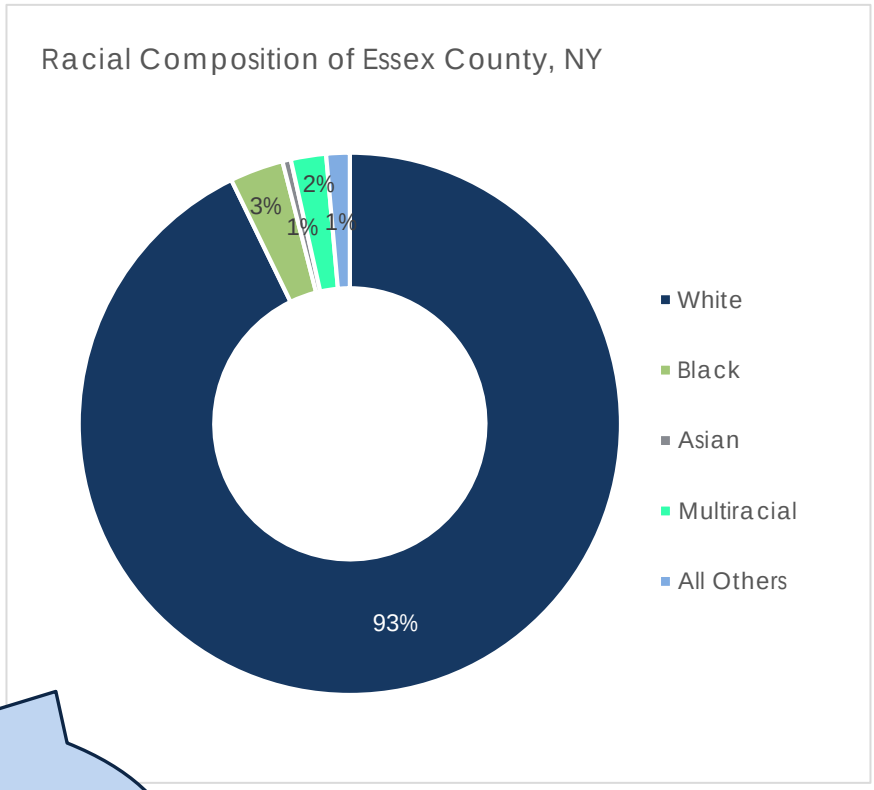
IN ESSEX COUNTY (5, 8, 63)

Residents of Essex County are increasingly racially diverse.

All racial groups (other than White) represent more of the resident population than ever before.

The population remain predominantly white (93%); more than 20 percentage points higher than NY (70%).

More residents are US or US Territory Born (97%); compared to NY (70%).



Social challenge write-in:

"Lack of diversity in the neighborhood."

Population Change (2010-2018) (8)

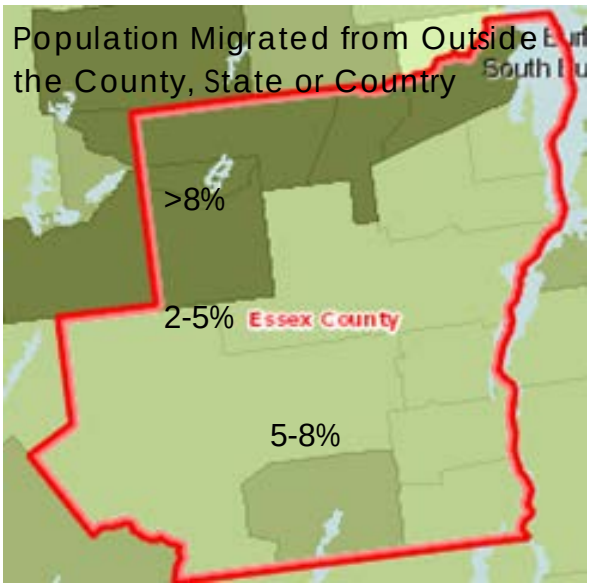
- 5%	Essex County
+1%	NY

Migration, Essex County (2006-2016) (8)

13,672	In
14,002	Out

In-Migration (8)

Immigration has been greatest in the northern and northwestern portion of the county as displayed (right). This is consistent with larger hub communities of Plattsburgh (north) and Saranac Lake (northwest).



 # International Migrants

25	2018
70	2017
70	2016

Since the previous comprehensive assessment in 2016, Essex County has become home to a growing number of Swartzentruber Amish families. Approximately 6 families enjoy life in the Champlain Valley region of Essex County in the communities of Willsboro, Essex, Westport, and Lewis. This is the largest known collective in-migration to the county. (17)

 # Domestic Migrants (8)

-118	2018
-32	2017
-176	2016

Young adults, ages 20-29, are the age group with the greatest percent (~17%) of out-migration. *(8)*

Language

WHY IT MATTERS

Language is one piece of human communication essential to people's ability to find, understand, make decision about and act upon health information. People speaking English as a secondary language or with limited English proficiency may find challenges in connecting to preventive and care related health services. (27)

IN ESSEX COUNTY

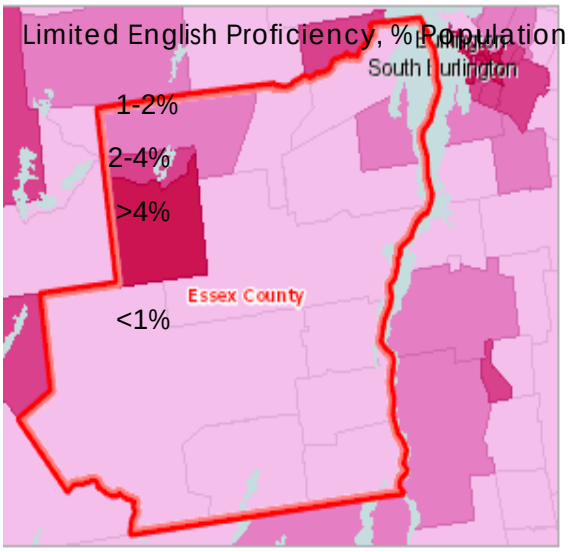
Non-English Speaking at Home (8)

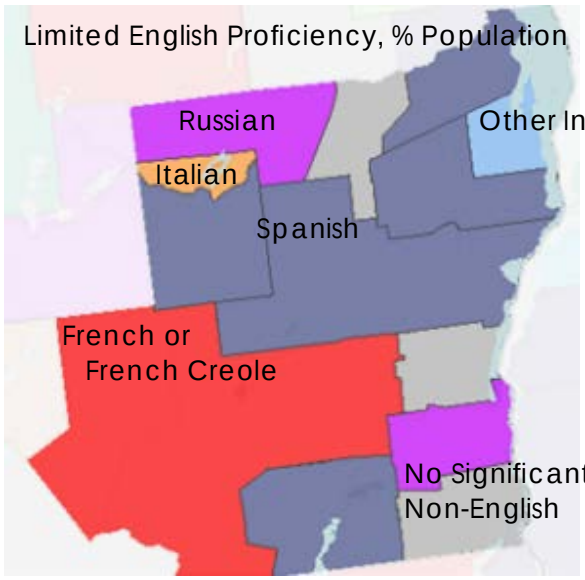
6% Essex

31% NY

As depicted at below, over 4% of the Lake Placid community and 1-4% of the Bloomindale, Wilmington and Willsboro communities reported limited English proficiency.

Spanish, French, Russian, Italian and other Indo-European are other spoken languages in Essex County Communities as depicted in the map below.

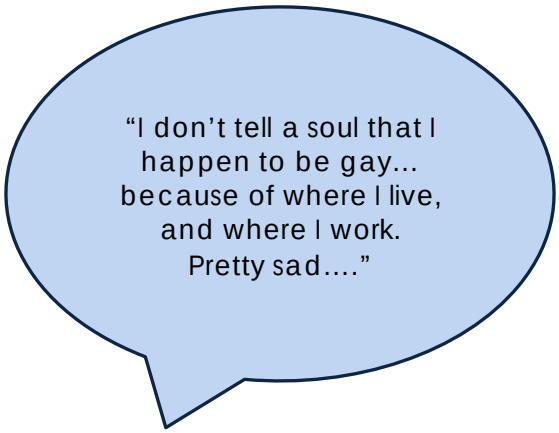




Sexual Identity

WHY IT MATTERS

People that identify as lesbian, gay, bisexual, transgender and/or queer (LGBTQ) are found in all races, religions, ethnicities and classes. People that identify as LGBTQ often face issues of social discrimination and denial of human rights. People face higher incidents of psychiatric and substance use disorders and may die by suicide. (27)



IN ESSEX COUNTY

Data systems are just beginning to collect information about sexual identification. At this time, there was no available information for Essex County except as captured in the Community Survey.

Public Safety/Crime and Violence

WHY IT MATTERS

Indicators of crime and violence can be important pieces of information in understanding community well-being and cohesion. People may be impacted by crime or violence by personally experiencing it, witnessing it, or living with the results of it. (27)

Physical impacts include injury and death while psychological impacts encompass a range of potential results such as depression, anxiety and other stress-related disorders. These impacts can be even greater for children. (27)

IN ESSEX COUNTY (5)

Crimes

Trend analysis [previous assessment in 2016 to now] of arrests for property and violent crimes demonstrate:

- an increase for adults
- a decrease for young adults (16-21 year olds)
- lower rates for adults & young adults than NYS.

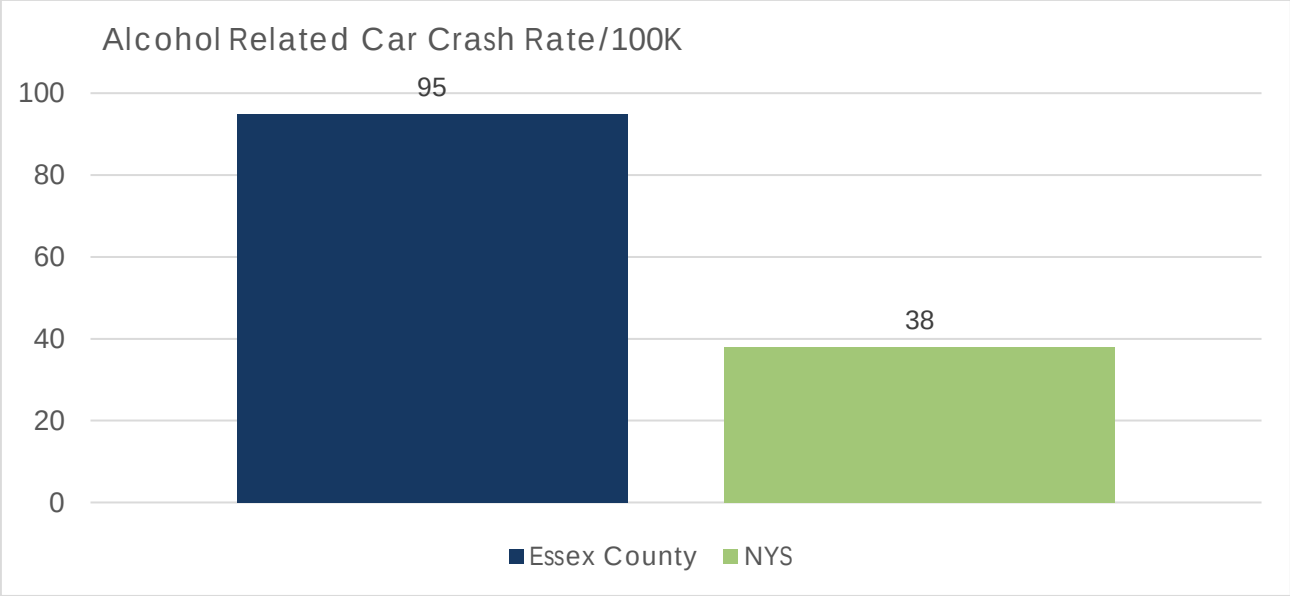
INDICATORS (/100k)	Essex Trend	Essex County Current	NYS
Arrests Property Crimes	▲	975.6	1466.1
Arrests Violent Crimes	▲	172.6	355.6
Young Adult (16-21) Arrests Property Crime	▼	43.0	106.7
Young Adult (16-21) Arrests Violent Crime	▼	12.9	56.9

Motor Vehicle Accidents (5)

Trend analysis of motor vehicle crashes including hospitalizations, deaths and those related to either speed or alcohol reveal:

- Hospitalizations for young adults is increasing though less than the NY average
- Crash rate is increasing & exceeds NY average
- Speed-related crash rate is increasing & exceeds NY average
- Alcohol-related crash rate (95/100K) is decreasing though 2 ½ times that of the NY (38/100K) average

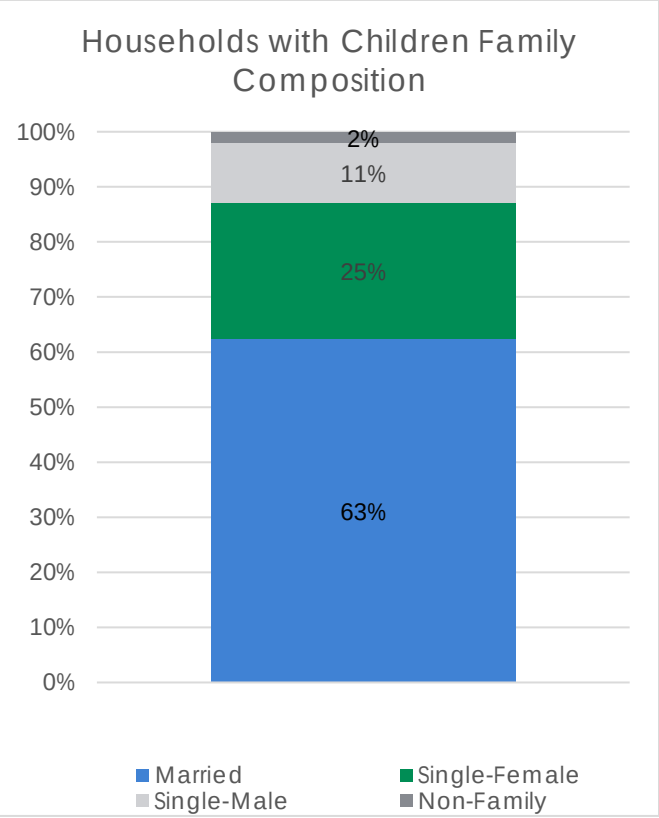
INDICATORS (/100K)	Essex Trend	Essex County Current	Essex County Compared to NYS	NYS
Motor vehicle crash hospitalizations young adult	▲	45.1	●	82.5
Motor vehicle crashes	▲	2779.5	●	1558.5
Speed related accidents	▲	685.0	●	141.6
Alcohol related crashes	▼	94.8	●	38.0



Households with Children

WHY IT MATTERS (10, 27, 28)

Psychosocial and physical health are largely influenced by human relationships. Families are a primary means of relationships and social connectedness. Family connectedness is identified as an essential protective factor for child and adolescent health outcomes including preventive health care and guidance in behaviors that influence health.



IN ESSEX COUNTY

The average household size in Essex County (2.32) is slightly smaller than NYS (2.63). (63)

The majority of families with children, 63% include a married couple. Single, female parents account for 25% of families with children; 11% are single, male parents. Two percent (2%) are non-family households. (63)

Foster Care (28)

WHY IT MATTERS

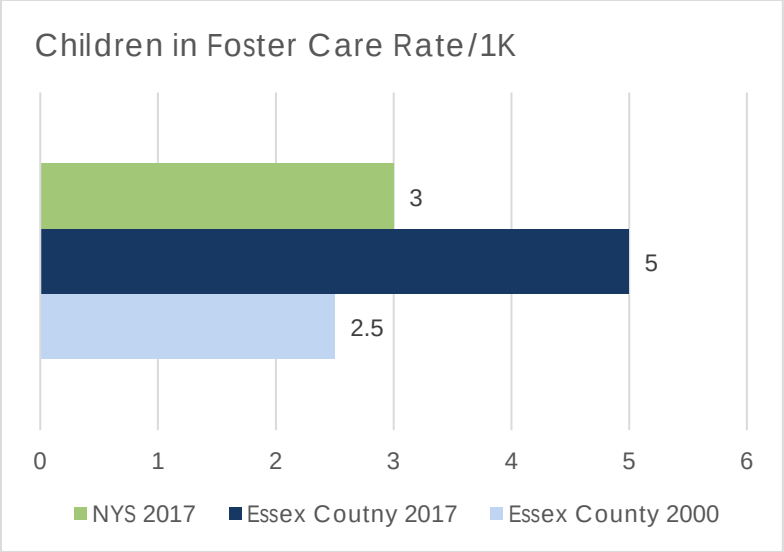
Children removed from families and admitted to foster care have often been exposed to health risks such as poverty, substance abuse, parental neglect and abuse. Children experience change and loss including parents, siblings, friends and community.

Fostering provides safety, stability & nurturing for children who often experience complex and serious problems. Yet these children still experience additional risks for medical, emotional, mental, behavioral, developmental, educational, and other health issues.

IN ESSEX COUNTY

In the year 2000 there were 12 children admitted to Foster Care (a rate of 1.6/1K). Assessed again in 2017 data demonstrates 27 children admitted for Foster Care in Essex County (rate of 3.1/1K) and higher than the same-year NYS rate of 1.7/1,000.

Foster Care children in care rate increased from 2.5 in 2000 to 5.0 in 2017; double and surpassing the NYS rate of 3.0.



Education

Early Childhood Education and Development

WHY IT MATTERS

Early childhood education, such as provided through licensed day care and early childhood programs, is closely connected to cognitive, social and emotional development with life-long lasting impacts. (27)

IN ESSEX COUNTY

Adirondack Community Action Program (ACAP) operates both Early Head Start and Head Start programs. These programs promote school readiness of children under 5 from low-income families through education, health, social and other services. (2)

1,455
Children Ages 0-5

ACAP is funded to provide services for 72 Early Head Start children and 125 Head Start children. These programs are conducted through home and center-based (Pre-K Collaboration) options.

Essex County Health Department facilitates an **Early Intervention Program** for children ages birth-3 with confirmed disability or established developmental delay. The program serves an average of 69 children each year (2015-2018) through in-home services. (17)

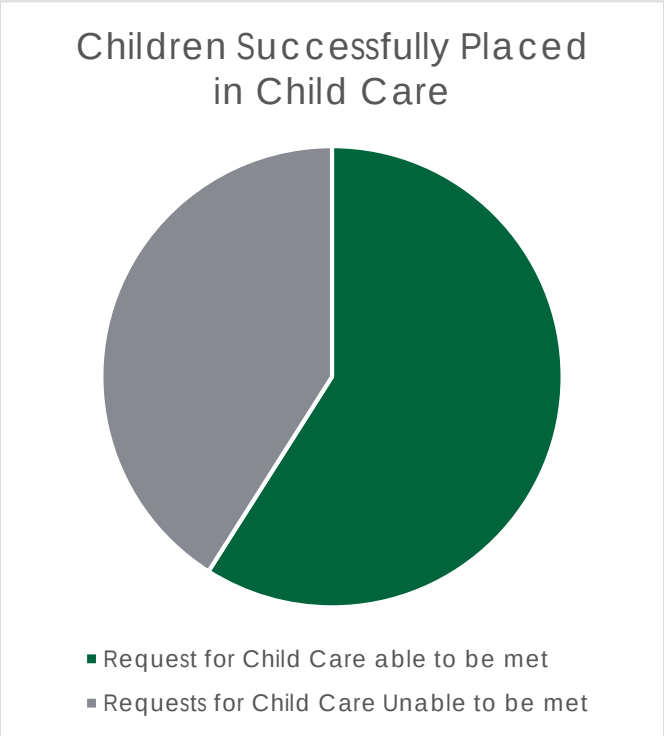
The Health Department facilitates a **Preschool Program** for children ages 3-5 who continue to need interventions to support their development. The program serves an average of 117 children each year (2015-2018) through in-home or center-based services. (17)

The Health Department also facilitates a **Children with Special Healthcare Needs Program** for children ages birth – 21 years who have a probable or diagnosed serious chronic physical, developmental, behavioral or emotional conditions needing services in an amount or type that exceeds those typically required by children. More than half of the children in the program are between the ages of 1 and 5. The program typically serves under 20 children per year. (17)

These programs collaborate with private agencies, independent service providers, ACAP, school districts and transportation agencies to ensure youngsters receive interventions needed to progress in their whole-person development. (17)

Child Care (1)

Adirondack Community Action Program (ACAP) is the local center for training, advocacy, education and referral management of child care.



Child Day Care Snapshot 2018

36	licensed/registered providers
21	legally exempt providers
1	small day care center
157	# children referred/need care
59%	% children successfully placed

Childcare was the 2nd most frequently identified need of community survey respondents in the 2018 Adirondack Community Action Program (ACAP) survey.

Availability and cost were identified by survey respondents as primary reasons for not using licensed/registered providers leaving those families turning to alternate care scenarios.

Preschool and Afterschool Care (17)

Preschool and afterschool program availability was assessed by school district and reveals a combination of operationalizing this need. This includes programs operated by ACAP, the school district, and private and/or town-operated programs as depicted below.

Preschool and Afterschool Care Availability by District

Public Districts K-12	Universal PreK	Afterschool	Operated by
Ausable Valley*	✓	✓	ACAP
Boquet Valley	✓	✓	ACAP
Crown Point	✓	✓	District
Keene	✓	✓	District
Lake Placid	✓	✓	Private
Minerva	✓	✓	District
Moriah	✓	✓	ACAP
Newcomb	✓	✗	District
Saranac Lake*	✓	✓	Private
Schroon Lake	✓	✓	ACAP
Ticonderoga	✓	✓	Private & Town
Willsboro	✓	✗	District

* Ausable Valley and Saranac Lake districts are just outside Essex County and serve Essex County residents.

Private Pre-schools include:
Lakeside School at Black Kettle Farm (a combined program for birth-3 years olds; Prek-K for 3.5-6 years olds plus early education for children in grades 1-3) and Little Peaks (for 3-5 year olds) in Keene.

K-12 Education and High School Graduation

WHY IT MATTERS

Continuous quality education supports short & long term educational attainment, earning potential, health behaviors and health outcomes. Students without basic reading proficiency, those living in poverty, and those who become pregnant during high school are less likely to achieve while in school and graduate. (27)

IN ESSEX COUNTY (51)

K-12 Students & Schools

3,618 K-12 Aged Students

11 Public School Districts

0 Charter Schools

4 Private Schools
Lakeside School at Black Kettle Farm (K-3)
North Country School (4-9)
Mountain Lake Academy (8-11)
Northwood School (9-12)

4 Religious Schools
Adirondack Christian School (K-11)
Mountainside Christian Academy (PreK-12) – Closed in 2019
St. Agnes School (K-6)
St. Mary's School (K-8)

ELA and Math Proficiency

Essex County students in grades 3-8 demonstrate English Language Arts (ELA) proficiency at 41% compared to the NYS at 45% for the 2018-2019 school year.

Subpopulations with scores less than comparison counterparts include students that are:
* Male * Multi-racial, Hispanic or Latino
* Disabled * Economically Disadvantaged or
* in Foster Care.

Students in grades 3-8 demonstrate mathematics proficiency at 39% compared to NYS at 46% for the 2018-2019 school year.

Subpopulations with scores less than comparison counterparts include students that are:
* Male * Black or Hispanic or Latino
* Disabled * Economically Disadvantaged * Homeless.

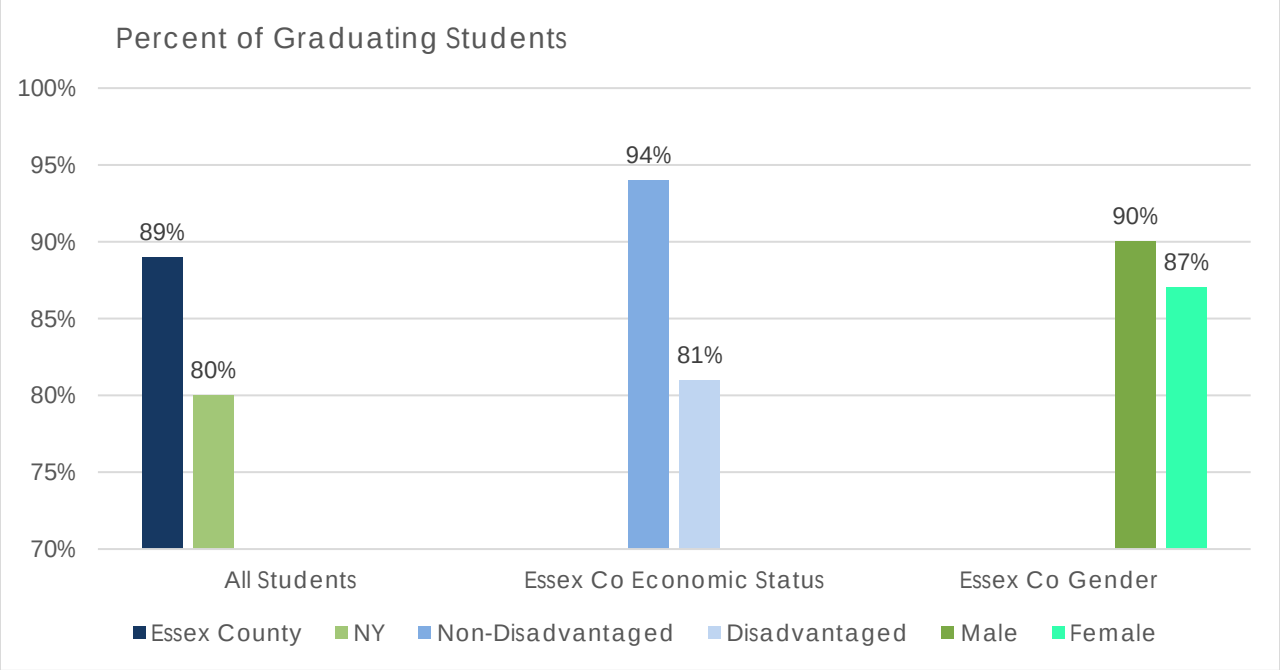
High School Graduation

WHY IT MATTERS

High School graduation is important for employment and earning opportunities across a lifetime. Student success is often the result of complex interactions including family, school and community context. (27)

IN ESSEX COUNTY

Graduation disparities in Essex County exist between economic status and gender. A higher percent of non-economically disadvantaged students graduate than economically disadvantaged students and a higher percent of male students graduate than female students. (51)



2018 Graduation Rates (2014 cohort)			
Public Districts K-12	Total # Students	Non-Economically Disadvantaged	Economically Disadvantaged
Crown Point	264	88%	85%
Elizabethtown-Lewis*	247	100%	56%
Keene	171	100%	100%
Lake Placid	647	100%	82%
Minerva**	97	100%	-
Moriah	676	96%	78%
Newcomb**	77	86%	-
Schroon Lake	237	100%	90%
Ticonderoga	745	88%	84%
Westport*	209	100%	83%
Willsboro**	248	79%	-

* Elizabethtown-Lewis CSD and Westport CSD merged to create a new district, Boquet Valley, starting the 2019-2020 school year. This merge was driven by declining enrollment, fiscal insecurity and incentives by NYS Department of Education.

** Graduation rate is listed as All (Non-Economically Disadvantaged and Economically Disadvantaged) for these districts because of the small number of students; no subcategories are available. Residents also attend neighboring districts of Saranac Lake and Ausable Valley.

Adult Literacy

WHY IT MATTERS

Adult Literacy includes oral, print, numeric, cultural and conceptual knowledge and communication skills. Such skills are important precursors to many aspects of life including knowledge access and higher educational attainment, employment, and ability to engage in preventive and health care across life. (27)

IN ESSEX COUNTY

The National Assessment of Adult Literacy estimates that in 2003 (the most recent data available) 12% of Essex County residents lack basic prose literacy skills; an increase from the 1992 estimate of 11%.

Higher Educational Attainment

WHY IT MATTERS (27)

Higher Educational Attainment is associated with improved economic security and health outcomes. Higher education equates to:

- better paying jobs with less risks
- increased ability to invest in health promoting goods and services
- improved ability to save for the future
- better housing in healthier communities
- more reliable transportation
- improved mental/psychological health
- increased socialization & community connection
- increased participation in leisure time activity and healthy living
- increased use of preventive health care
- increased ability to understand and follow healthcare treatment regimens.

IN ESSEX COUNTY

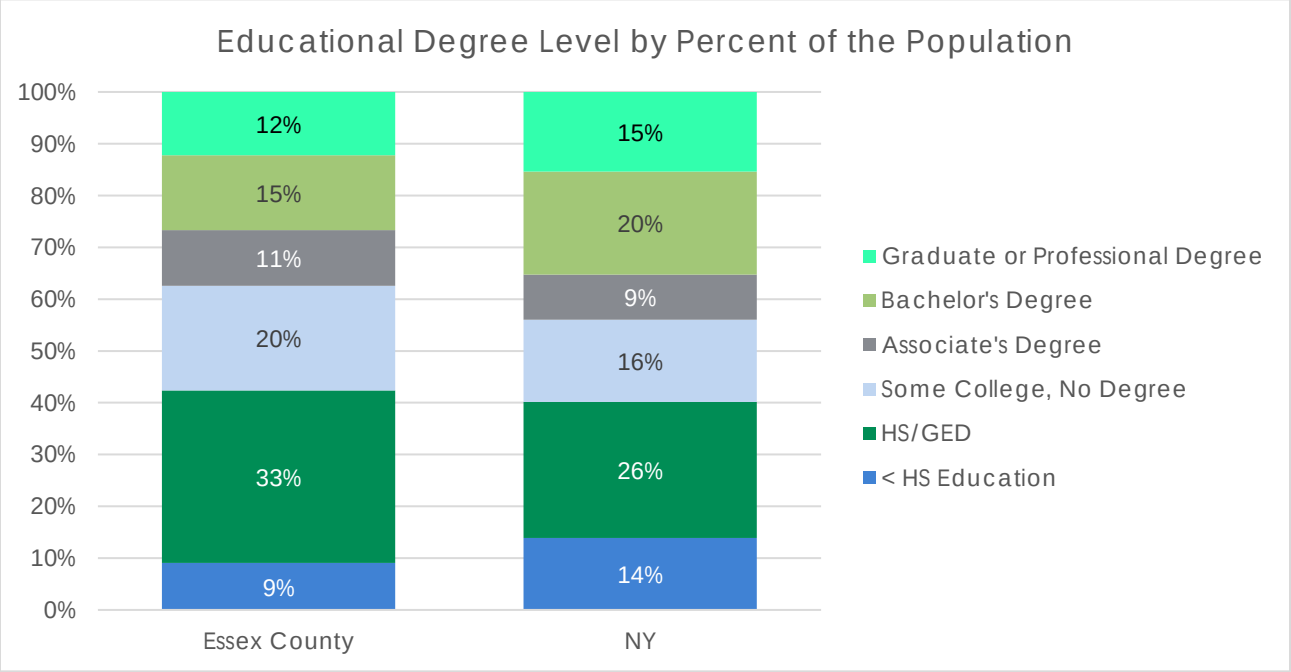
*Higher Education Opportunities in the Region (*53, 17)

The North Country Community College main campus is in Saranac Lake, a shared village of Essex and Franklin Counties, with an extension campus in Essex County's Ticonderoga.

Clinton Community College in Plattsburgh is a nearby option for students. The SUNY College of Environmental Science and Forestry has a campus in southern Essex County. Other North Country regional SUNY colleges include Adirondack to the south in Glens Falls; Plattsburgh to the north; Canton and Potsdam to the west.

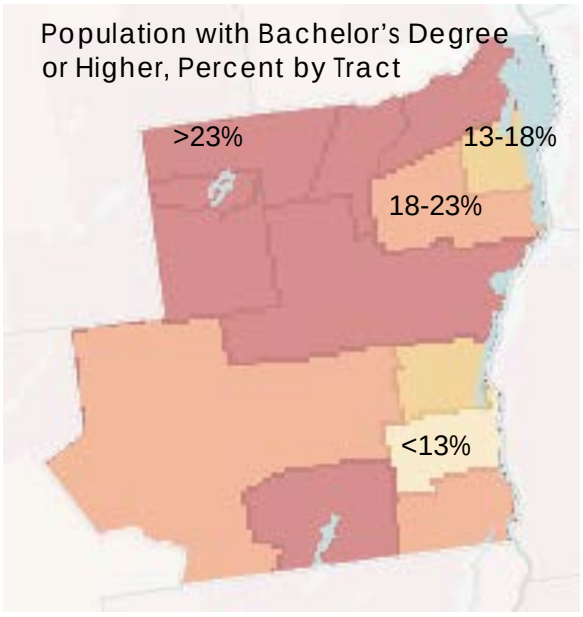
Private colleges in the region include St. Lawrence University, Clarkson University, and Paul Smith's College of Arts and Science. Students also venture to nearby Vermont to colleges and universities in Burlington and Middlebury.

Essex County residents compare better than the state for residents aged 25 and older with less than a High School Education and Associate's Degree though not as many residents complete Bachelor's, Professional or Graduate level Degrees. (63)



The map to the right demonstrates the percent of the population by town.

When comparing Educational Attainment with Median Family income by community one can see a similar alignment of higher education aligning with higher income (See Economic Stability section). (8)



Neighborhood and the Built Environment

Housing

WHY IT MATTERS (x)

Affordability, neighborhood context, stability, and quality are identified as housing pathways known to impact health outcomes and costs.

49%
said **Affordable Housing** is important to a strong, vibrant & healthy community.

IN ESSEX COUNTY

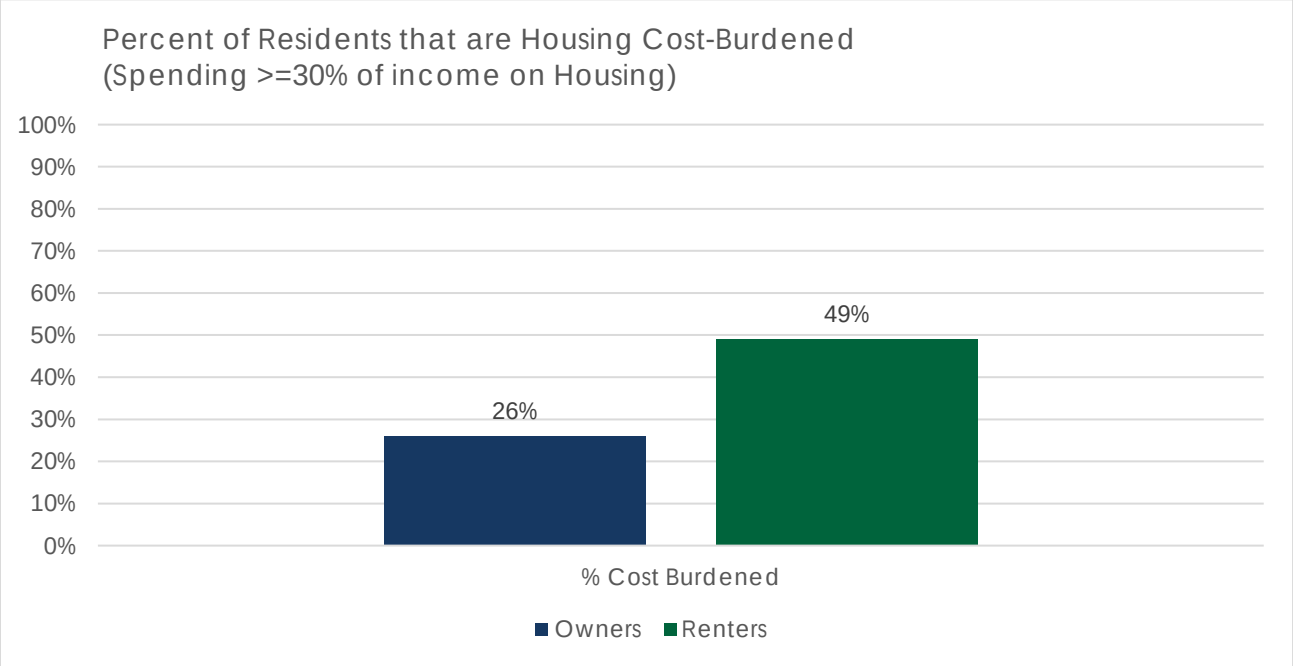
Affordability:

Approximately ¼ of homeowners are considered cost-burdened by housing; that is, spending over 30% of income on housing. This burden is more widely experienced by renters as approximately ½ of renters are so burdened. (x, 63)

	Own	Rent
% Occupied	76%	24%
Annual Cost	$15,108	$8,736
Cost ≥ 30% income	26%	49%

Housing burden equates to:

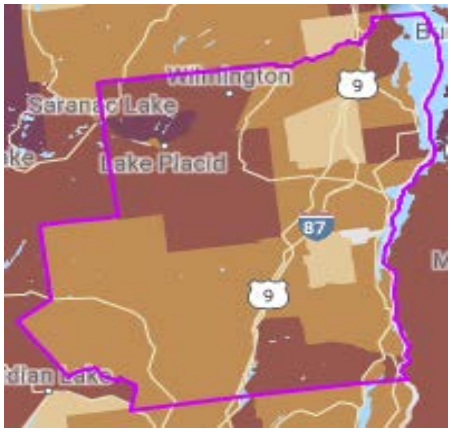
* difficulty affording basic necessities
* increased physical and mental distress
* inability to purchase health-generating goods
* inability to financially invest in the future.
* hardship in affording health care.



Home sale prices increased substantially in Essex County from 2006-2016 from a median price of $140K to $175K. In the North Country region this is one of the greatest increases during this time frame. (53) Ownership impacts stability and security of residents and economic stability of the community as a whole. (x)

The maps at right depict average monthly owner and renter costs by community. (8)

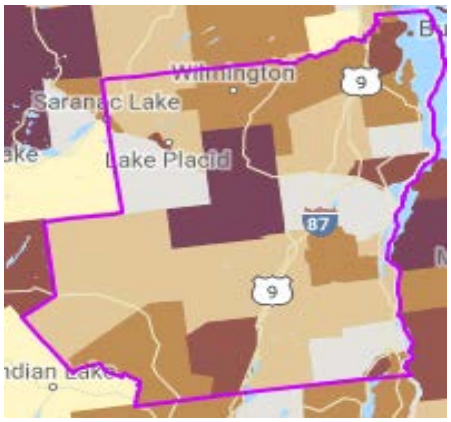
Average owner costs (map to the right top) are highest in the Village of Lake Placid and towns of North Elba, Bloomingdale, Wilmington, areas of Keeseville, Essex and Schroon; lowest in the Town of Lewis and portions of Moriah.



Owner Costs/ Community
average monthly

< $700
$700-1000
$1000-1,300
$1,300-1,800
$1,800+

The highest average renter costs (map to the right bottom) are in the Town of Keene followed by portions of Schroon and Keeseville.



Renter Costs/ Community
average monthly

< $600
$600-750
$750-925
$925-1,200
$1,200+

Neighborhood context: Discrepancies of affordability by community exist within the county for owning and renting. (9)

56% of Stakeholders identified Neighborhood & Built Environment to be excellent or close to excellent.

Quality: Essex County housing is younger than that of the region & NYS with 43% being under 50 years in county compared to 32% in state. (63)

Stability: Housing vacancy in Essex County is increasing and currently estimated at 41% compared to 11% in NY state. (63)

Security: Those experiencing housing insecurity is improving with a current rate of 29% in Essex County compared to 35% in NY. However residents identify the need for senior housing options. (63)

"There is no housing option for HEALTHY seniors."

Transportation

WHY IT MATTERS (27)

Transportation is tightly related to other social determinants of health including:

* access to employment & higher education
* access to resources to meet daily needs, engage in wellness & maintain community connections
* access to health services and
* costs as % of family income.

"There should be community vans or other means of transportation for the elderly who aren't driving."

32% Transportation is a community challenge

IN ESSEX COUNTY

Essex County can be described as a sparsely populated, rural community with limited public transportation and ability for residents to use active transportation to meet their needs. Transportation was one of the most frequently identified social challenges by residents through the Resident Survey and Stakeholders through the Distributed Focus Group.

Average Costs and Economic Impact (9)

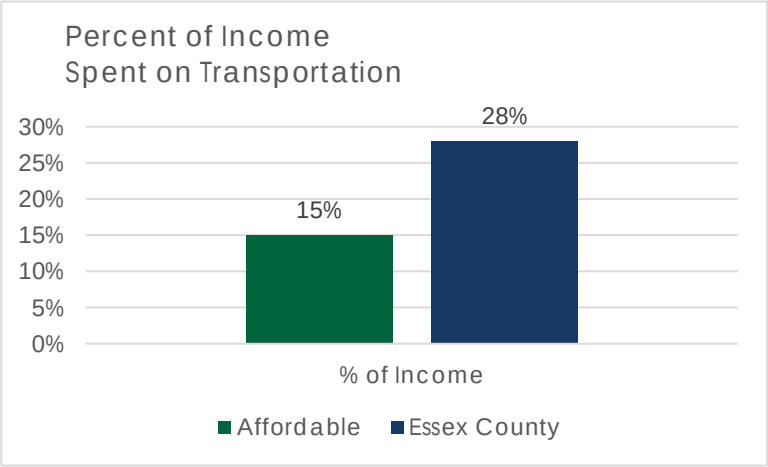
Annual household costs include vehicle ownership/lease, maintenance & fuel. The percent of household income that Essex County residents spend on transportation, 28%, exceeds what is considered affordable, 15% or less of income.

$14, 653	Annual Household Cost
2	vehicles/household average
23,791	vehicle miles travelled/year

Vehicle Availability (5)

Residents largely rely upon personal vehicles for transportation with about 93% of families having one or more vehicles available to them; nearly 20% higher than the NY average of 71%.

% of Households	Essex	ARHN Region	NY
0 vehicles	7.5%	8.5%	29.0%
1 + vehicle	92.5%	91.5%	71%



Public Systems- Bus and Rail (20)

Essex County Transportation Department operates 9 buses on 4 regular routes within the county and coordinates with inter-county routes to Plattsburgh in Clinton County and Saranac Lake in Franklin County.[1] This service provides limited relief for reliance upon personal vehicles for resident needs. Long-trip, limited service passenger railway running North-South along the Lake Champlain valley and partial railway tourism routes equate to extremely limited use of railway transportation as a regular transportation option for residents.

Broadband

WHYT IT MATTERS (34)

Access to high speed internet has increasingly become recognized as an important and even super-determinant of health. This is because it influences other social determinants of health – with education and employment at the forefront. It is also necessary for healthcare services, access to healthcare and community economic development.

It is recognized that the digital divide is severe in rural communities, such as Essex County. Those that are older, have lower levels of education and income are less likely to have broadband access at home.

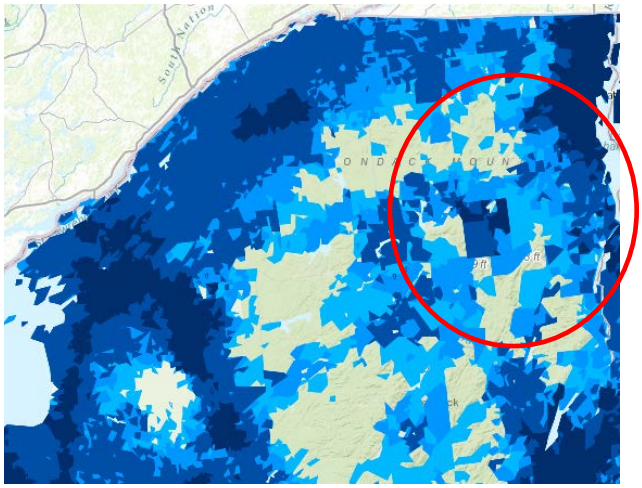
Access is complex with factors including

- Coverage
- Type of Service/Technology
- Providers
- Price
- Speed

IN ESSEX COUNTY (22)

Availability in Essex County varies (see map on the right) with increased accessed in population hubs including the Lake Champlain and Lake Placid areas and no or limited access in the south-west region of the county.

LGE Coverage by Number of Providers-2017



Households with Computer

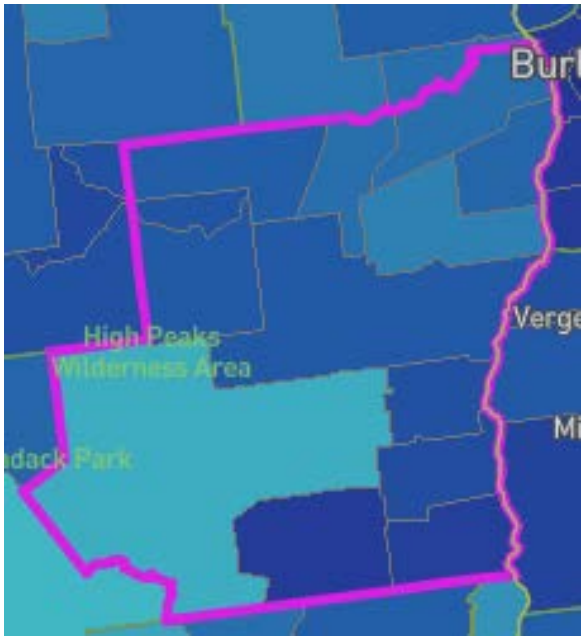
85% Essex
87% NY

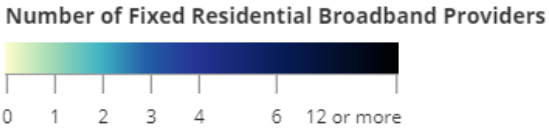
Households with Internet Subscription

Dial-up, cable, fiber optic, DSL, Satellite or other

75% Essex
79% NY

14 Providers in Essex County





The connection of broadband and health will continue as an area of exploration with further visual overlay of broadband and health data at the national, state and county levels. (23)

Food Access

WHY IT MATTERS

Access to healthy foods support health over the course of a lifetime and lower risks for chronic conditions. Conversely, inability to access healthy foods or abundant access to unhealthy foods and beverages can increase risk for chronic conditions and decrease quality of life. People that are low-income and have limited transportation experience the greatest barriers to healthy foods. Older adults living in rural communities are also identified as an at-risk sub-population. (27)

IN ESSEX COUNTY

More recent than data depicted in the map (right) identifies the continued closure of grocery store chains in the county; most recently in the Village of Port Henry/Town of Moriah in 2019. Newcomb, Minerva and North Hudson are considered food deserts given there are no such establishments within 10 miles. Some communities have smaller family-owned establishments that fill the gaps for residents. (17, 8)

3,630 Residents are Food Insecure (24)

9.5% Essex County
11.4% NYS

7 **Chain Grocery Stores** include Tops Market (4); Hannaford (1); Price Chopper (1); Walmart (1).

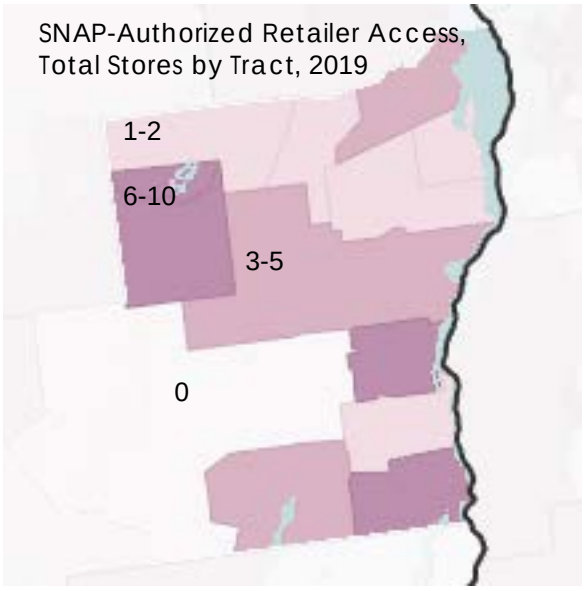
42 **SNAP Retailers** include grocery stores, convenience stores and others (Dollar stores).

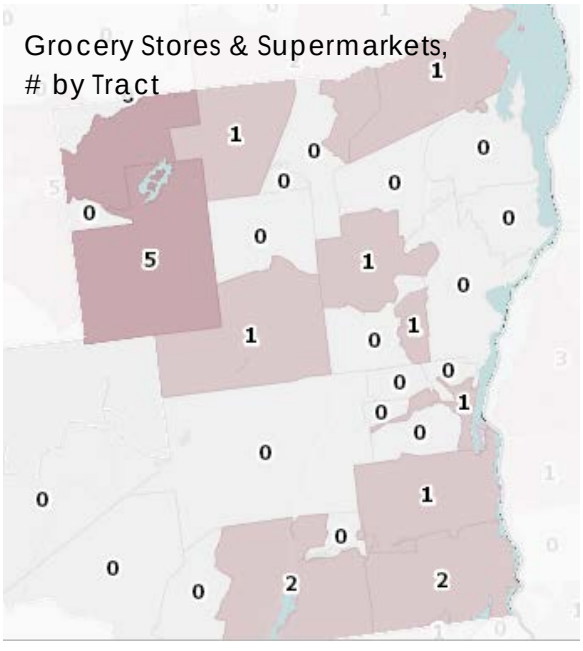
6 **WIC Vendors** are grocers that meet stocking requirements for WIC-approved healthy foods.

7 **Farmers' Markets** sell local produce, meats, dairy and artisan goods at outdoor markets.

17 **Food Pantries** are faith-based and independently operated organizations with unique policies and practices for distribution. Only a few partner with the Regional Food Bank.

10 **Better Choice Retailers** are locally owned marts that achieve minimal stocking requirements for healthy foods in a variety of food groups.





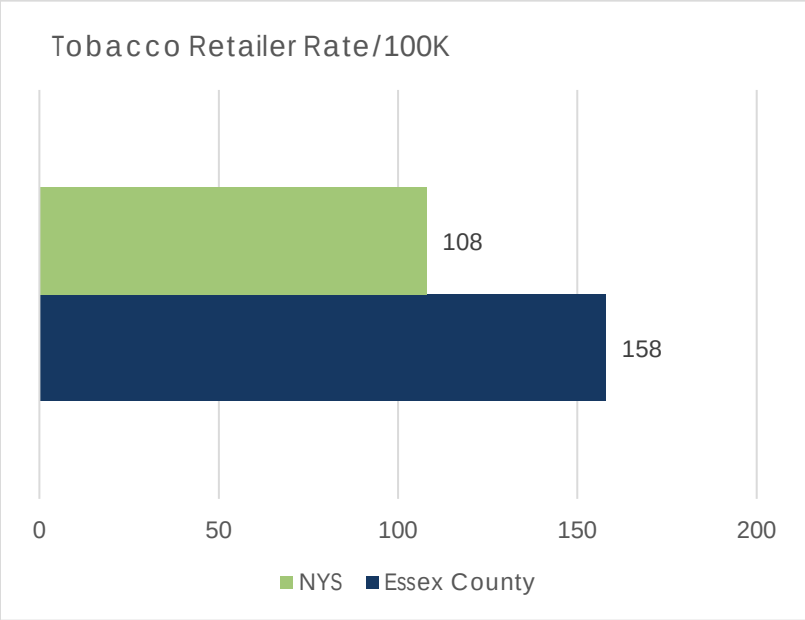
Tobacco

WHY IT MATTERS

Smoking is the leading cause of chronic disease including lung disease, heart disease & stroke. Retail availability supports social norms of tobacco use, increases point of sale advertising, increases accessibility and availability of products, increases brand recognition and perpetuates social environmental inequities. Limiting tobacco vendors is just one piece of a comprehensive tobacco control program. (14)

IN ESSEX COUNTY

There are 57 Tobacco Retailers in Essex County.
This equates to a rate/100K of 158; higher than the NY rate of 108. (5)



Town	# Retailers
Chesterfield	1
Crown Point	1
Elizabethtown	5
Essex	0
Jay	2
Keene	2
Lewis	2
Minerva	2
Moriah	8
Newcomb	0
North Elba	14
North Hudson	1
St. Armand	1
Schroon	4
Ticonderoga	8
Westport	3
Willsboro	2
Wilmington	1
TOTAL	57

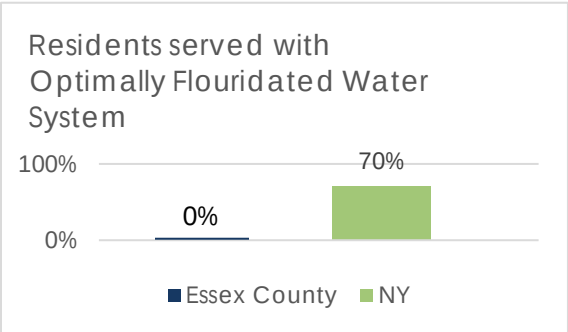
Public Water Systems

WHY IT MATTERS (10)

Public water supplies are protected from sources of contamination such as naturally occurring chemicals/minerals and biologicals, land use practice elements, manufacturing process elements and sewage. Community water fluoridation has been used for over 70 years as a means to prevent tooth decay and improve oral health.

IN ESSEX COUNTY (41)

21	public water systems
0	include water fluoridation systems
31,513	people served by these systems



Natural Environment

WHY IT MATTERS (10, 27)

Air quality, water pollution and heat are three environmental factors identified as having significant impacts on human health with an estimated 11% of deaths in the US due to environmental causes.

Outdoor air pollutants include ozone and particulate matter; indoor air pollutants may be associated with housing-related exposures such as insects, rodents and tobacco.

Groundwater pollutants include exposure to septic, landfill and agricultural runoff and include waterborne diseases.

Hottest Days on Record have been in the most recent decade as reported the National Oceanic and Atmospheric Administration. (33)

Vulnerable populations including the very young and very old and those with existing chronic health conditions are at increased risk for environmental health risk exposures. Economically disadvantaged communities are at increased risk of environmental health hazards.

IN ESSEX COUNTY

Air Quality (5)

0 Unhealthy Ozone/ Particulate Matter Days

Water Quality

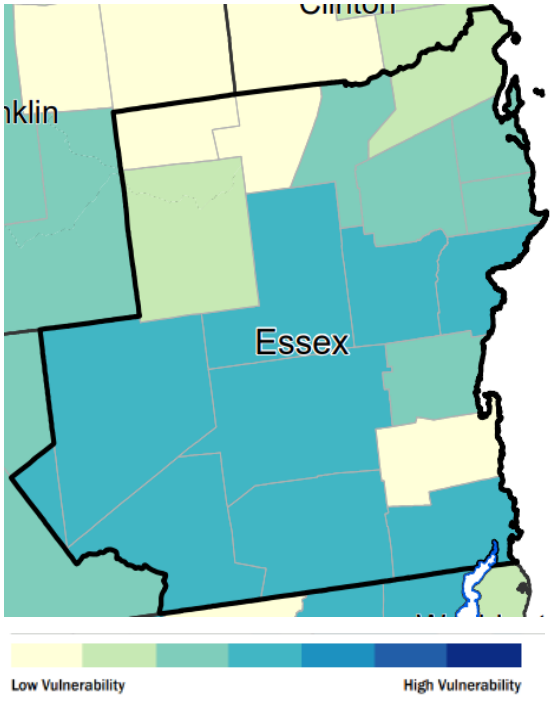
The 21 public water systems in Essex County are monitored locally with support by the NYSDOH District Office that covers Essex, Franklin and Hamilton Counties.

Heat

NYSDOH developed a Heat Vulnerability Index (HVI) to help local jurisdictions identify and map local communities where vulnerable populations exist based on 4 categories:

* Language,
* Socio-Economic,
* Environment and
* Elderly.

The map on the right depicts a combined HVI score by town in Essex County.



16 Designated cooling centers in Essex County

During the 2019 year Essex County Health Department partnered with the Clinton-Essex-Franklin Library System to Designated Cooling Centers at 16 local libraries in Essex County. (17)

Climate and Health

WHY IT MATTERS (10)

Part of the natural environment in which we live includes climate and effects of climate change on human health. The Centers for Disease Control and Prevention (CDC) identify 8 categories in which a changing climate impacts human health:

- Severe Weather
- Extreme Heat
- Air Pollution
- Change in Vector Ecology
- Water Quality Impacts
- Increasing Allergens
- Water and Food Supply Impacts
- Environmental Degradation

Climate Change was the #3 Environmental Health issue identified in the Community Survey

Climate Smart Communities Pledge (5)

100%	Essex County
36%	NY

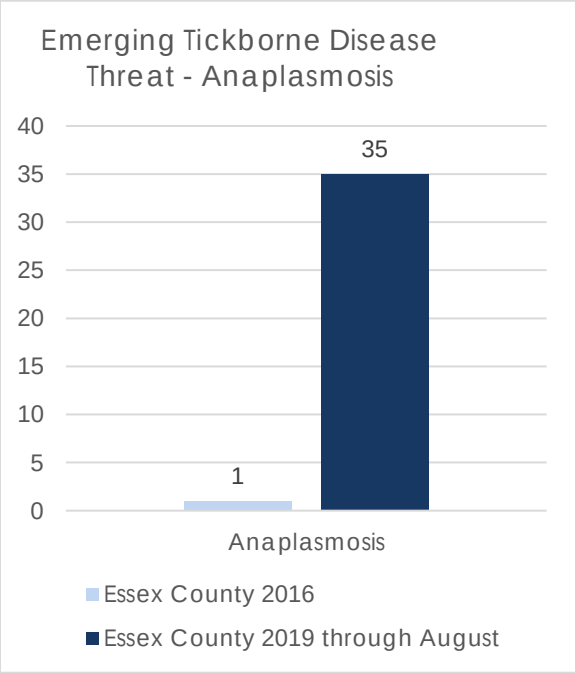
IN ESSEX COUNTY

Essex County has experienced the effects of a changing climate. Highlighted here are:

* **Change in Vector Ecology** - tick-borne diseases

* **Water Quality Impacts** - harmful algae blooms

* **Severe Weather** - disaster declarations



Tick-borne diseases

Tick surveillance conducted by NYSDOH in Essex County during the 2017 year revealed that Lyme-Disease infected ticks continue to be a public health threat in Essex County. (46)

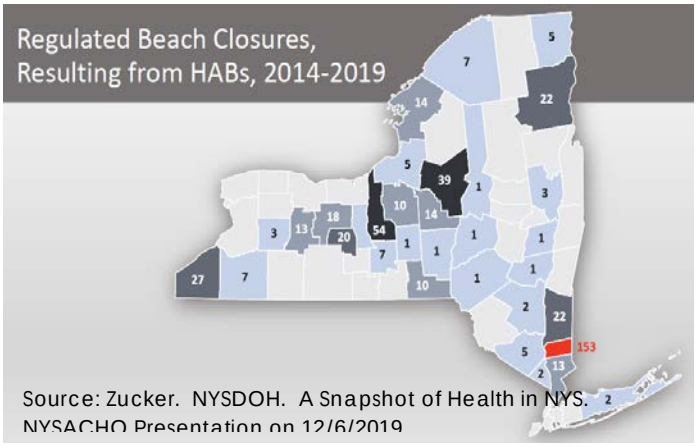
Emerging public health threats due to pathogen-infected ticks include Anaplasmosis and Babesiosis. With only 1 confirmed case of Anaplasmosis in 2016, the 2019 case number through only August of 2019 demonstrates this emerging threat locally. Case of Babesiosis remain less than 10. (17)

Vector-borne diseases was the #1 Environmental Health issue identified in the Community Survey

Harmful Algae Blooms (41)

Notable increases in reports of Harmful Algae Blooms (HABs) have occurred since the 2016 assessment. HABs are an increasing public health risk throughout NY and Essex County.

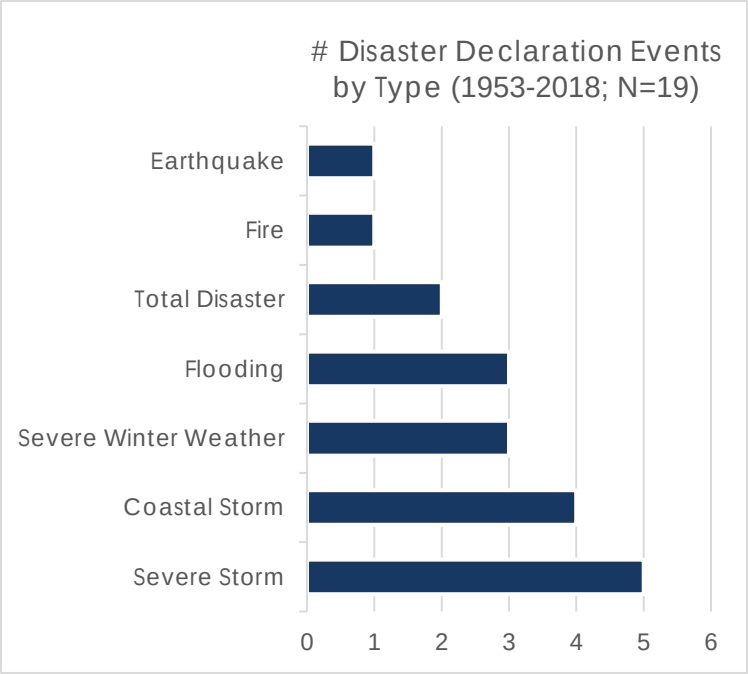
From 2014-2019 there were 22 beach closures due to HABs in Essex County. This is important for humans and economic health [given the recreation-dependent economy of Essex County].



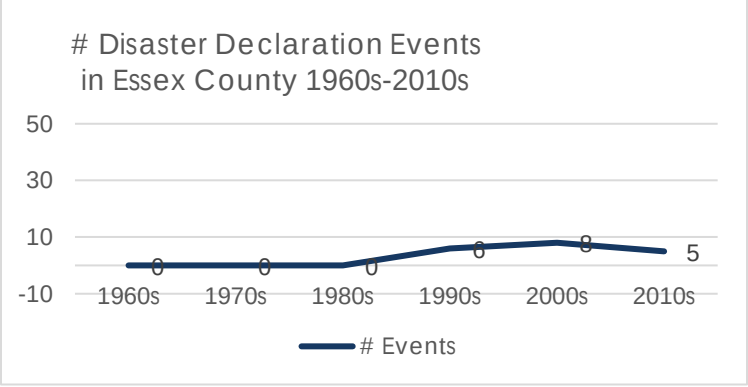
Stream, river & lake quality was the #2 Environmental Health issue identified in the Community Survey

Disaster Declarations (8)

Disaster events and declarations are only those events of a magnitude that exceeds combined capacities of local and state governments; not all severe instances of weather events able to be addressed with local/state resources.



Disaster declarations have increased over an extended period of time from the 1960s through the 2010s as depicted at right with severe storms being the most common type of disaster locally.



Economic Stability

Local Economy

WHY IT MATTERS

Work is a fundamental aspect of people's lives impacting the personal physical, psychological and social well-being of workers and their families. (8)

It influences:

* health insurance and health care access;
* food, housing and transportation resources;
* household expenses (taxes, childcare, technology and recreation) resources; and
* financial investment and savings capacity.

IN ESSEX COUNTY (65)

The USDA Economic Research Service typology codes classifies Essex County is economically dependent on **Government** & **Recreation** from 6 types of 1) farming, 2) mining, 3) manufacturing, 4) Federal/State government, 5) recreation, and 6) nonspecialized counties.

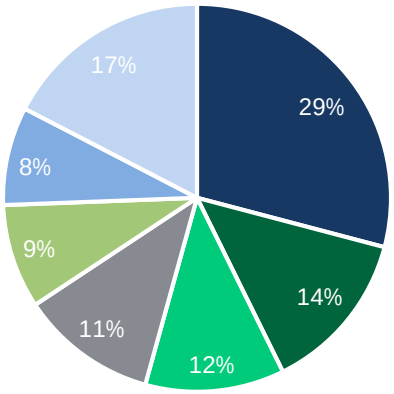
Government-dependence is based on the percent of jobs or earnings from fed/state government. Recreation-dependence is based upon measurement of jobs & earnings in relevant sectors plus dedicated seasonal housing.

Essex County does not meet thresholds for classification within any of the policy-relevant types: 1) low education, 2) low employment, 3) persistent poverty, 4) persistent child poverty, 5) population loss, and 6) retirement destination.

Economic Dependence (65)

Government

Recreation



- Education, Healthcare & Social Assistance
- Arts, Entertainment, Recreation, Food Service & Hotels
- Retail Trade
- Public Administration & Other Professional Occupations
- Manufacturing
- Construction
- Other: Professional Occupations; Finance; Tranportation, Warehouse, Utilities; Agriculture, Forestry, Fishing, Hunting, Mining; Information Services; Wholesale Trade

Adequate Income and Poverty

WHY IT MATTERS (27, 60)

Adequate incomes help people:
* avoid stress and feel in control,
* access experiences and material resources,
* adopt and maintain healthy behaviors, and
* feel supported by a financial safety net.

It allows people to pursue higher education, engage in meaningful work, find secure housing, access healthy foods, and live with improved mental health.

Household Survival Budget - Essex, New York, 2016

	Single Adult	2 Adults, 1 Infant, 1 Preschooler
Housing	$532	$844
Child Care	$0	$1,250
Food	$182	$603
Transportation	$341	$682
Health Care	$213	$792
Technology	$55	$75
Miscellaneous	$158	$491
Taxes	$262	$664
Monthly Total	$1,743	$5,401
ANNUAL TOTAL	$20,916	$64,812
Hourly Wage	$10.46	$32.41

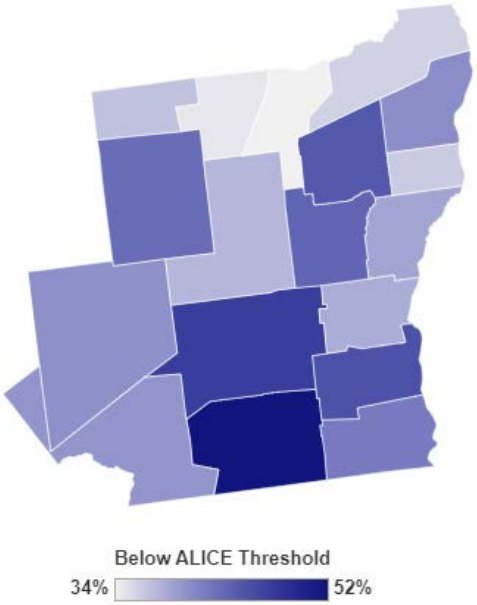
Source: U.S. Department of Housing and Urban Development; U.S. Department of Agriculture; Bureau of Labor Statistics; Internal Revenue Service; Tax Foundation; and New York State Office of Children & Family, 2016.

ALICE=

Asset Limited, Income Constrained, Employed

ALICE individuals and families are working with an income above the federal poverty level but below a sustainable wage.

The bare minimum cost of living in the modern economy, as estimated by a Household Survival Budget (depicted right) continues to increase.
The Survival Budget does not include savings making it difficult for families to cover unexpected expenses or contribute to financial investments for the future such as college or retirement.



IN ESSEX COUNTY (65)

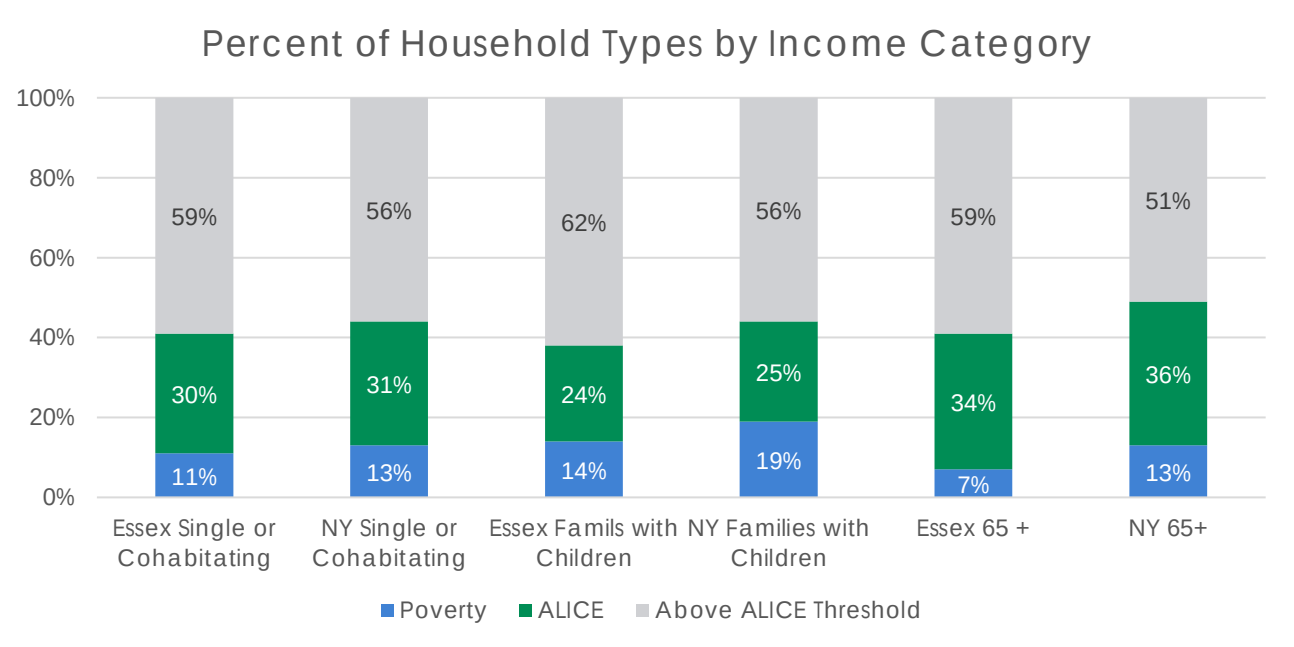
Geographic analysis demonstrates the greatest percent of ALICE households to be in the Village of Witherbee (73%) and Port Henry (53%) both in the Town of Moriah followed by the Town of Schroon at 52%.

Analysis of the percent of households by the types of income categories reveal (65):

- the highest percent of people living in poverty in Essex County are families with children (14%) followed by people that are single or cohabitating (11%) and seniors of age 65 and older (7%); and
- the highest percent of people meeting the ALICE threshold in Essex County are seniors of age 65 and older (34%); followed by people that are single or cohabitating (30%) and families with children (24%).

Analyzing the data by the percent of household types that are living in poverty or meeting the ALICE threshold reveals the following:

- 41% of people that are single or cohabitating
- 38% of families with children
- 41% of seniors of age 65 and older



Unemployment and Poverty (5)

The unemployment rate demonstrates a decrease in Essex County; currently 3.8%. This is near the Adirondack Region at 3.7% and better than the NY average at 4.3% Other indicators for poverty reveal Essex County fairs better than NYS for children living below poverty, children & youth receiving SNAP or Public Assistance, the percent of individuals receiving Medicaid and the per capita Medicaid expenditures.

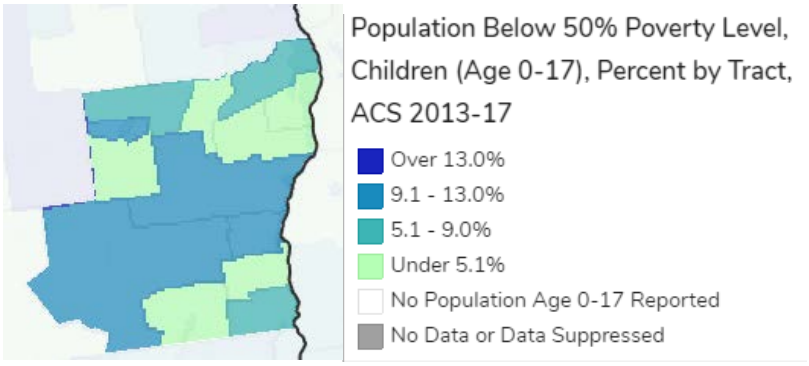
INDICATORS	Essex County	NY
Children & Youth Living Below Poverty %	16.8	19.9
Children & Youth Receiving SNAP (rate)	17.7	24.5
Children & Youth Receiving Public Assistance	2.1	6.3
Individuals receiving Medicaid %	20.4	24.8
Per capita Medicaid expenditures	$8,028	$9,670

Extreme/Deep Poverty by Age Ranges and Geography (9)

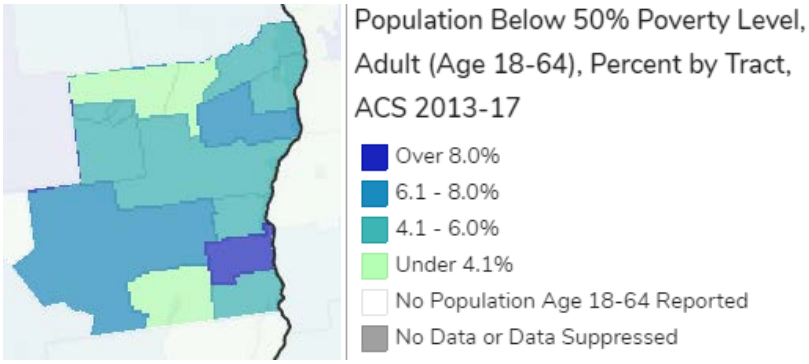
Extreme poverty threshold levels are federally determined and vary by family size and composition. Population below 50% poverty level refers to people that are living at significantly below the federal poverty level; this is also termed extreme or deep poverty.

The following three figures provide a visual display of the percent of people living below 50% the federal poverty level based on township. It is notable that the use of color in these visual displays represent different percent ranges for each image. For example, the darkest color for children is equal to 13+%, for adults ages 18-64 8+% and for seniors aged 65+ over 3%.

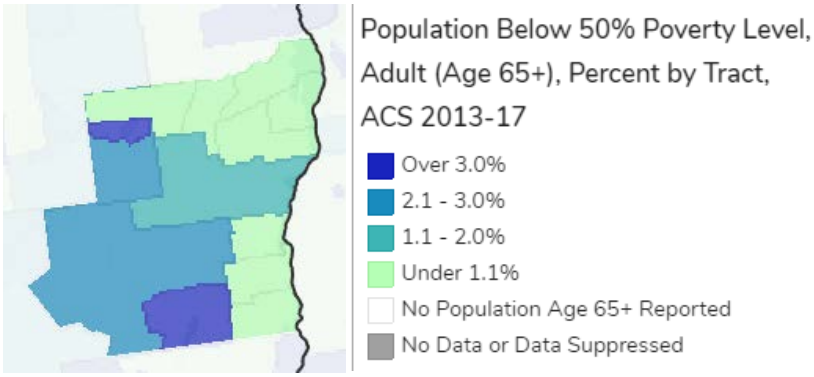
The percent of children living in deep poverty are lowest (under 5.1%) in the towns of North Elba, Jay, Lewis, Willsboro, Schroon and Crown Point. There are no townships where 13% or more of the children ages 0-17 are in extreme poverty.



The lowest percent of adults ages 18-64 living in deep poverty (under 4.1%) are in the towns of Bloomingdale, Wilmington, Jay and Schroon Lake. The highest (over 8%) is in the Town of Crown Point.



The lowest percent (under 1.1%) of adults in deep poverty are in the towns of Bloomingdale, Wilmington, Jay, Chesterfield, Lewis, Willsboro, Moriah, Crown Point and Ticonderoga. The highest percent (over 3.0%) is in the Village of Lake Placid and the Town of Schroon.



SECTION 3: ASSETS

Working across community sectors effectively and efficiently requires a comprehensive understanding of those sectors and the assets available within each. Assets are identified as resources available to the community that can be mobilized to address community health needs and contributing factors.

To better identify those assets and align the strengths of Essex County an asset assessment was conducted as the final initiative of Step 1: Assess Needs and Resources [of the Take Action Cycle].

For this Section of the CHA, ***Essex County Health Partners*** categorized assets as:

- Healthcare System
- Coalitions and Committees
- County Government Departments
- Community Based Organizations
- Media
- Law Enforcement
- Education Systems
- Religious Groups
- Local Programs and Grants, and
- New York State Health Department and Associations.

These categories were considered across NYSDOH Prevention Agenda Priority Areas and the cross-cutting disparity for Essex County residents; Access to Healthcare.

This information was organized into an Asset Matrix (following).

Essex County Health Partners recognize the benefit of additional asset mapping including broader considerations such as programs and policies directly or indirectly influencing health and as related to additional Social Determinants of Health.

Asset identification was an essential part of informing priority selection as described further in the next Section; Section 4: Focusing on What's Important.

Asset Matrix		KEY: Engaged in the development of the CHA & CHISP.	KEY: Resources available to mobilize in addressing community health.					
			Prevention Agenda Priorities & Cross-Cutting Disparity in Essex County					
Asset Type	Name	Description	Chronic Diseases	Healthy & Safe Environment	Healthy Women, Infants & Children	Well-Bring & Mental/ Behavioral Health	Communicable Diseases	Access to Healthcare
Healthcare System	Adirondack Health-Adirondack Medical Center	Population Health Committee	■	■	■	■	■	■
		Decker Learning Center for Health Education	■	■	■	■	■	■
		Health Centers - Providers & Wellness Coaches	■	■	■	■	■	■
		Physical, Occupation & Speech Therapy Programs		■				■
		Car Seat Technicians & Car Seat Clinics		■				■
		Women's Health Clinic			■			■
		Breast Program: Breast Health Navigator	■					■
		Certified Lactation Consultants			■			■
		Certified Car Seat Technicians. Car seat clinics.			■			■
		Antibiotic Stewardship Program					■	■
		OD Reversal Program				■		■
		Buprenorphine Clinic				■		■
		Medication Drop Box				■		■
		Dr. First Pharmacist-Led Medication Reconciliation				■		■
		Respiratory Therapy Program	■					■
		Cancer screenings & the Merrill Center for Oncology	■					■
		Weight Management Program	■					■
		Medical Fitness Program	■					■
		Fit for Life (Medically-Supervised Activity)	■					■
		Population Health Committee	■	■		■		■
	UVHN-Elizabethtown Community Hospital	Health Centers - Providers & Social Workers	■	■	■	■	■	■
		Diabetes Educator, Prevention Program, Support Group	■					■
		Cancer Screenings & Events; Chemo infusion Therapy	■					■
		Physical, Occupation & Speech Therapy Programs	■					■
		Nutritionist, Wellness Rx Program & co-located food pantries	■		■			■
		Wellness Program	■		■			■
		Tobacco Cessation Specialists	■		■	■		■
		Pulmonary & Cardiac Rehabilitation Programs	■					■
		Breastfeeding- Friendly Health System			■			■
		Stop Domestic Violence Program			■			■
		Specialty Care Outpatient Clinics	■		■	■		■
		Opioid Stewardship & MAT				■		■
		Medication Drop Box and Community Narcan distribution				■		■
		Ryan White Grant					■	■
		Antibiotic Stewardship Program					■	■
	Hudson Headwaters Healthcare Network		■	■	■	■	■	■
	Pharmacies					■	■	■
	Essex County Health Department	Public Health Advisory Board	■	■	■	■	■	■
		Public Health Unit Programs	■	■	■	■	■	■
		Children's Services Unit Programs			■			■
		WIC Unit			■			■
		Home Health Unit	■	■	■	■	■	■
	Adirondack Health Institute (AHI)	Adirondack Rural Health Network	■	■	■	■	■	
		Population Health Improvement Program (PHIP)	■	■	■	■	■	
Adult Care Facilities			■	■			■	
Nursing Homes			■	■			■	■
Senior Living Facilities			■	■			■	

Asset Matrix		KEY: Engaged in the development of the CHA & CHISP.	KEY: Resources available to mobilize in addressing community health.					
			Prevention Agenda Priorities & Cross-Cutting Disparity in Essex County					
Asset Type	Name	Description	Chronic Diseases	Healthy & Safe Environment	Healthy Women, Infants & Children	Well-Bring & Mental/ Behavioral Health	Communicable Diseases	Access to Healthcare
Coalitions/Committees	Adirondack Birth to Three Alliance				■			■
	Essex County Breastfeeding Coalition		■		■			
	Well Fed Essex County Collaborative		■					
	Essex County Drug Court				■	■		■
	Essex County Heroin & Opioid Prevention Coalition (ECHO)			■	■	■	■	■
	Essex County Suicide Prevention Coalition				■	■		
	Essex County Community Services Board					■		
	Essex County Human Services Committee	Sub-Committee of the Board of Supervisors				■		
	Human Services Coalition	Committee of ACAP				■		■
	Essex, Clinton, Franklin Immunization Action Plan Coalition						■	■
	Essex, Clinton, Franklin Lead Poisoning Prevention Coalition				■			
	Safe Kids Adirondack				■			
	Local Emergency Planning Committee			■	■		■	
	Housing Coalition				■	■		■
	Rural Communities Opioid Response Planning (RCORP)				■	■		
County Government Departments	Mental Health					■		■
	Department of Social Services				■	■		■
	District Attorney					■		■
	Office for the Aging		■			■		■
	Public Works & Transportation		■	■				
	Sheriff					■		
	Emergency Services & EMS			■		■		■
	Community Resources/Planning		■	■		■		
	Youth Bureau		■		■	■		
	Transportation			■				■
	Veteran's Services		■			■		■
Local Government	Towns & Villages	Boards, Planning, Zoning		■				
Media		Print, Radio, TV, Social	■	■	■	■	■	■
Law Enforcement		NYSPD, Essex County Sheriff, Local				■		
Community-Based Organizations	Alliance for Positive Health		■	■	■	■	■	■
	Adirondack Foundation		■	■	■	■	■	
	The Prevention Team					■		
	Mental Health Association in Essex County					■		■
	Planned Parenthood of the North Country				■	■	■	■
	Adirondack Community Action Program (ACAP)	Human Services Coalition	■	■	■	■		
	Families First				■	■		
	North Country Healthy Heart Network (NCHHN)		■	■	■	■		
	Retired Senior Volunteer Program (RSVP)							■
	St. Joseph's Addiction Treatment & Recovery Center					■		■
	Behavioral Health Services North					■		■
	Tri-Lakes Center for Independent Living		■					■
	Mountain Lake Services		■					■
	Cornell Cooperative Extension		■		■			
	Industrial Development Association		■	■				
	Housing Assistance Program of Essex County		■	■				
	Literacy Volunteers of Essex & Franklin Counties							■
	Chambers of Commerce	Local & Regional	■	■				
	Businesses		■		■	■		
	United Way of Clinton, Essex, Franklin County							■
	One Work Source							■
	Champlain Valley Family Center		■			■		
Schools		Public, Private, BOCES, Colleges	■	■	■	■	■	

Asset Matrix		KEY: Engaged in the development of the CHA & CHISP.	KEY: Resources available to mobilize in addressing community health.					
			Prevention Agenda Priorities & Cross-Cutting Disparity in Essex County					
Asset Type	Name	Description	Chronic Diseases	Healthy & Safe Environment	Healthy Women, Infants & Children	Well-Bring & Mental/ Behavioral Health	Communicable Diseases	Access to Healthcare
Religious Groups	Churches, Ecumenical Societies, etc.							
Local Programs/Grants	Cancer Services Program of Northeastern NY							
New York State (NYS)	NYS Association of Counties (NYSAC)							
	NYS Association of County & City Health Officials (NYSACHO)							
	NYS Public Health Association (NYSPHA)							
	Healthcare Association of New York State (HANYS)							
	Home Care Association of New York State (HCA-NYS)							
	NYS Department of Health (NYSDOH)							

SECTION 4: PRIORITIZATION

Step 2: Focus on What's Important

Prioritization was informed through numerous steps as taken by ***Essex County Health Partners***:

1. ***Analyzing regional and local data and contributing factors*** as documented in this CHA:

- Health Indicators (Section 1)
- Contributing Factors (Section 2)
- Community Engagement Results (Sections 1 & 2)

2. ***Identifying Disparities*** during the data analysis process:

Within Section 1: Health, disparities were identified within each priority area specific to indicators including:

- Age
- Gender
- Geography/Communities within the county
- Socio-economics as Medicaid/Non-Medicaid.

Within Section 2: Social Determinants of Health, Access to Healthcare was identified as a cross-cutting disparity for Essex County residents and include barriers of Geography, Transportation and Provider Shortages.

3. ***Identifying local assets*** that can be mobilized to address needs & disparities (Section 3).

4. ***Using a prioritization matrix*** with internal planning groups of:

- Essex County Health Department
- University of Vermont Health Network-Elizabethtown Community Hospital
- Adirondack Health-Adirondack Medical Center.

The prioritization matrix was a locally-modified version of the Hanlon Method that included criteria categories of need and feasibility (30). The matrix was guided by asking questions regarding the scope and severity (need) of health issue and the perceived ability to impact and community readiness (feasibility) regarding addressing those health issues.

Health issues were categorized and scored following the five (5) NYSDOH Prevention Agenda areas (48):

- Prevent Chronic Disease
- Promote a Healthy & Safe Environment
- Promote Healthy Women, Infants & Children
- Promote Well-Being and Prevent Mental Health & Substance Use Disorders
- Prevent Communicable Diseases

Internal planning groups of ***Essex Health Partners*** identified priorities as:

- Prevent Chronic Disease (3 of 3 groups)
- Promote Healthy Women, Infants & Children (2 of 3 groups)
- Promote Well-Being and Prevent Mental Health & Substance Use Disorders (3 of 3 groups)

5. ***Sharing preliminary findings and requesting feedback*** from:

- Essex County Health Department Public Health Advisory Committee (PHAC)
- Essex County Board of Supervisors (BOS)
- Essex County Community Members

6. ***Drawing a conclusion to address 3 priorities*** in the Community Health Improvement/Service Plan (CHISP):

- **Prevent Chronic Disease**
- **Promote Healthy Women, Infants & Children**
- **Promote Well-Being and Prevent Mental Health & Substance Use Disorders**

Identification of these priorities concludes Steps 1 and 2 of the Take Action Cycle and this Part II: Community Health Assessment (CHA) 2019 of the full report.

PART III: COMMUNITY HEALTH IMPROVEMENT/SERVICE PLAN 2019-2021

Executive Summary

PART I: Introduction

PART II: Community Health Assessment 2019

PART III: Community Health Improvement/Service Plan 2019-2021

PART IV: Dissemination Plan

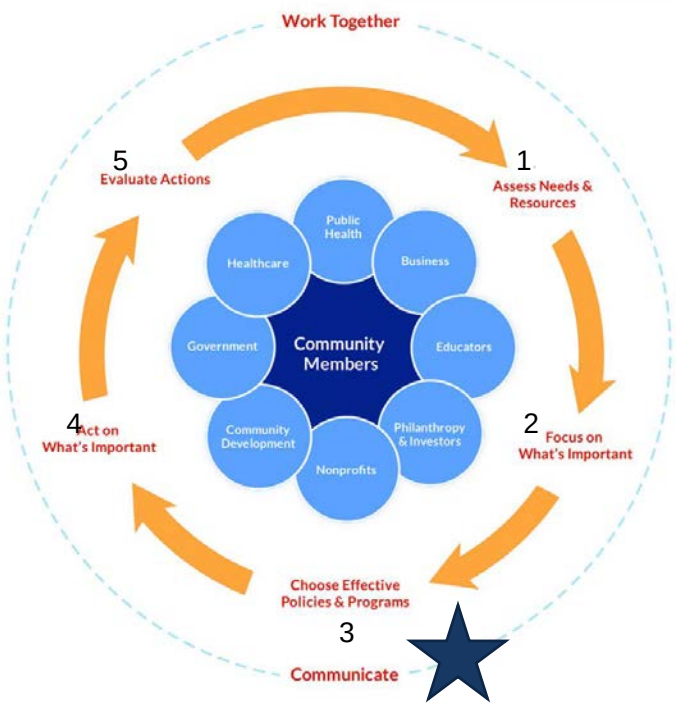
Part V: Appendices

Continuation of the Take Action Cycle

Part I, the Introduction and Part II, the Community Health Assessment, provide the basis for Part III, the Community Health Improvement/Service Plan (CHISP).

Selecting interventions and identifying appropriate lead and partner organizations would not be possible without a sound understanding of the county profile, health data, social determinants of health, and assets and challenges that the health of the region is predicated upon. A CHISP that results in collective progress and measurable health improvements is rooted in this foundational work.

Take Action Cycle



Take Action Cycle Steps 3-5 are included in this Part III: CHISP of the full report.

Step 3: Choosing Effective Policies & Programs

Planning was informed through long-standing relationships between ECHD, hospitals, community based organizations and stakeholders. This includes ongoing collaboration and communication directly between and among community based partners and stakeholders.

The process to select strategies that address the three (3) priorities and disparities occurred through the convening of Priority Area Workgroups with other community based organizations/partners.

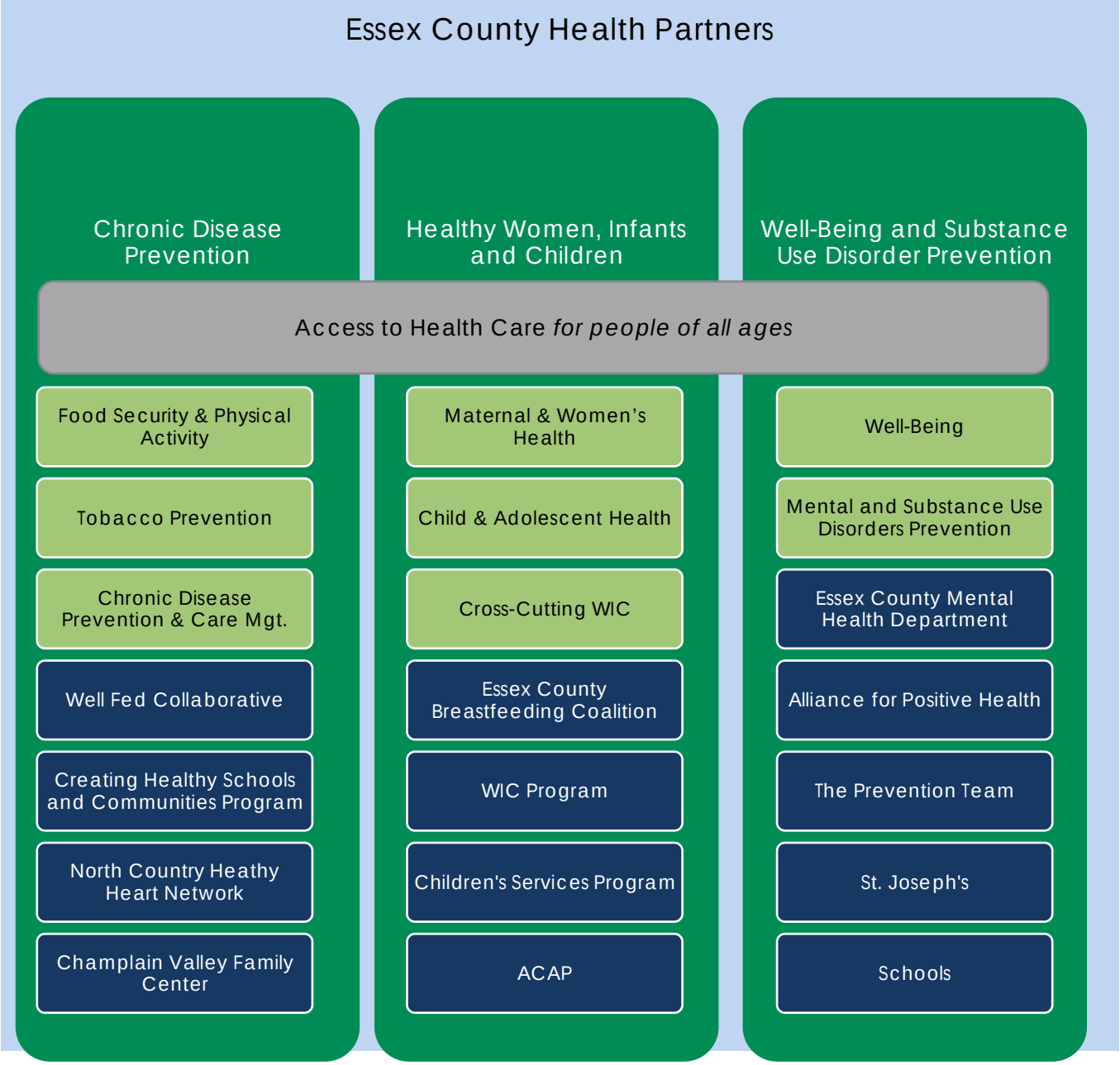
Workgroups started with a sound understanding of the county profile and considered:

- Data leading to these the priority areas
- Disparities experienced by sub-categories of populations within these priority areas
- Social Determinants of Health contributing to priority outcomes and disparities
- Evidenced-based interventions as directed by NYDOH Prevention Agenda
- Assets that may be mobilized to address health needs
- Lead organizations for specific interventions and community based partners essential to intervention success

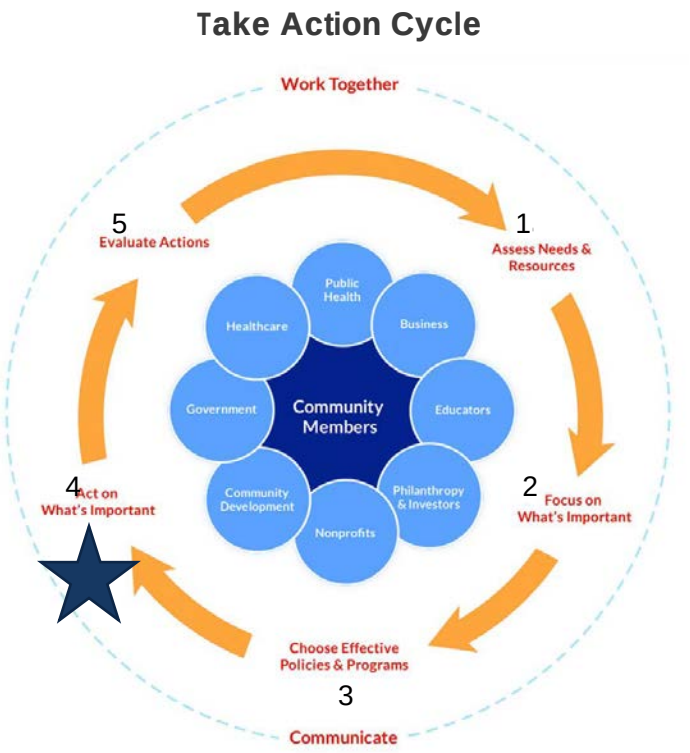
Workgroups further assessed data with partner expertise gained from working within the priority area. Discussions centered on:

- drilling down through contributing factors to the true root cause(s) that lead to poor health outcomes and disparate health indicators in certain communities, groups, locations;
- evaluating existing assets/programs/initiatives; and
  - selecting the strategies that are most likely to result in measurable health gains; address the disparities identified; and be implemented successfully among partners.

The graphic on the following page depicts that Essex County Health Partners (in light blue) oversaw the identification of three (3) health priorities (in green) and focus areas (in light green) with the cross-cutting disparity of Access to Healthcare (in grey). It also demonstrates the engagement of community based organizations, programs and partners (in dark blue) in the development of interventions.


Essex County Health Partners
Chronic Disease Prevention
Healthy Women, Infants and Children
Well-Being and Substance Use Disorder Prevention
Access to Health Care for people of all ages
Food Security & Physical Activity
Tobacco Prevention
Chronic Disease Prevention & Care Mgt.
Well Fed Collaborative
Creating Healthy Schools and Communities Program
North Country Heathy Heart Network
Champlain Valley Family Center
Maternal & Women's Health
Child & Adolescent Health
Cross-Cutting WIC
Essex County Breastfeeding Coalition
WIC Program
Children's Services Program
ACAP
Well-Being
Mental and Substance Use Disorders Prevention
Essex County Mental Health Department
Alliance for Positive Health
The Prevention Team
St. Joseph's
Schools

Step 4: Acting on What's Important



Interventions in this CHISP include an array of strategies to improve population health including:

- Coalitions and other community planning efforts;
- Policy, systems and environmental changes;
- Public health marketing and campaigns;
- Outreach, education, training and technical assistance;
- Delivery of early detection and guideline-concordant health care; and
- Application of new technologies in healthcare and improved care coordination.

The following elements are included in the CHISP Work Plan (Attachment 10).

<u>NYSDOH Prevention Agenda Identified:</u>

- Priority
- Focus Area
- Goal

<u>Locally Identified:</u>

- Objectives
- Disparities
- Interventions
- Family of Measure for Evaluation
- 3 Years of Planned Activities
- Partners
- Partner Roles and Resources.

Examples of Process measures included:

- Number of trainings provided
- Number of media campaigns and engagement
- Number of policies revised and updated
- Number of health practices screening and referring
- Number of smoke-free housing unit, parks and playgrounds
- Implementation of updated guidance related to priority areas
- Number of programs offered and residents served

A summary of the CHISP interventions are listed in the tables following. These tables demonstrate the commitment of ***Essex County Health Partners*** and community based organizations in both taking the lead with interventions and working collaboratively on interventions.

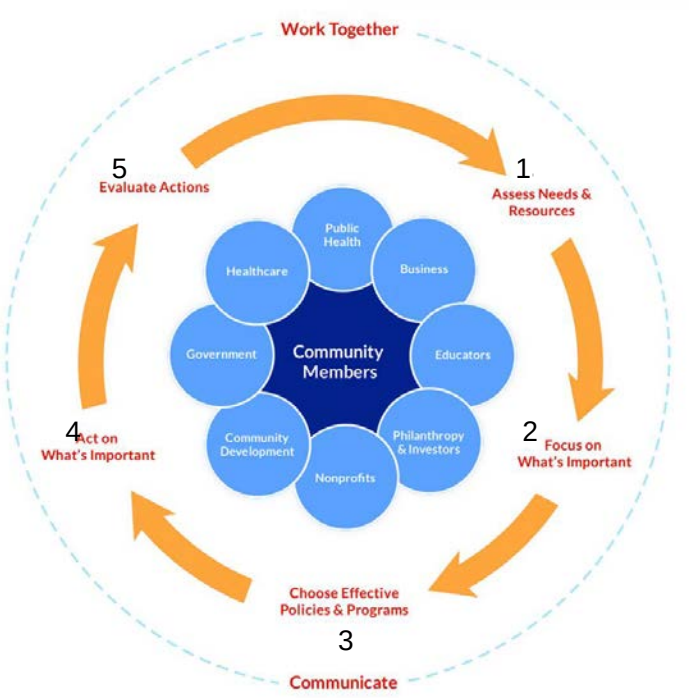
Priority and Focus Areas	Intervention	Lead	Partners
CHRONIC DISEASE			
Healthy Eating & Food Security	Worksite nutrition & physical activity programs	UVHN-ECH	
	School-based obesity prevention	ECHD	Schools
	Increase the availability of fruit & vegetable incentive programs	UVHN-ECH	ECHD
	Food insecurity referral	ECHD / UVHN-ECH	AMC
Tobacco Prevention	Facilitate medical / behavioral practices in delivering tobacco Tx	NCHHN	UVHN-ECH/AMC
	Health communications & marketing to promote tobacco use Tx	ECHD / UVHN-ECH	Media
	Encourage healthcare provider involvement in patient quit attempts	NCHHN	UVHN-ECH/AMC
	Promote smoke-free housing	CVFC	
	Increase smoke-free parks/playgrounds	CVFC	
Chronic Disease Prevention & Care Management	Systems change for cancer screening reminders	UVHN-ECH/AH	
	Media to build community demand	UVHN-ECH/ECHD	Media
	Provider assessment & feedback on screening services	UVHN-ECH	
	Remove barriers to screening	UVHN-ECH	
	Access to health insurance to increase screening	UVHN-ECH	
	Improve detection of undiagnosed hypertension	UVHN-ECH	
	Promote testing for pre-diabetes/diabetes	UVHN-ECH/AH	
	Team approach to chronic disease outcomes	UVHN-ECH/AH	
	Referral for those with pre-diabetes to DPP	AH	NCHHN
	Expand access to CDSM	AH	
	Expand access to NDPP	UVHN-ECH/AH	NCHHN

Priority and Focus Areas Focus Area	Intervention	Lead	Partners
Well-Being/Mental Health / Substance Use Disorder			
Promote Well-Being	Social/emotional support across a lifespan	UVHN-ECH	
	Resilience for people living with chronic conditions (LEAD)	ECHD	
	Promote inclusion, integration and competence	AH	
Mental and Substance Use Disorder Prevention	School based prevention: Life Skills Training	Prevention Team	Schools
	Trauma-informed approaches into prevention programs (BRIEF/MindUp)	EC Mental Health	
	SBIRT	UVHN-ECH	
	Integrate trauma-informed approaches and responses	UVHN-ECH	
	Availability/access to MAT	UVHN-ECH	
	Availability/access to OD reversal	AH	St. Joseph's
	Prescriber education regarding opioid guidelines/limits	AH/UVHN-ECH	
	Safe disposal sites & take-back days	AH/Alliance for Positive Health	
	Integrated nicotine / mental health Tx	AH	

Priority and Focus Areas Focus Area	Intervention	Lead	Partners
Healthy Women, Infants, Children			
Maternal & Women's Health	Health insurance enrollment	AH	
	Reproductive goal setting in routine health visits	AH	
	Capacity and competencies of local maternal and infant home visiting programs	ECHD	
Child & Adolescent Health	Oral health messaging in programs serving WIC	ECHD	ACAP/Media
Cross-cutting WIC	Collaborate to address social determinants of WIC (Maternal Health Agenda)	ECHD	AH/UVHN-ECH

Essex County Health Partners will share the CHISP with the ARHN Forum to facilitate regional planning and identification of additional regionally-based activities.

Step 5: Evaluating Actions



Essex County Health Partners and the community based organization partners engaged in the planning of the CHISP have pledged on-going commitment to the health and well-being of Essex County residents.

Minimally, ***Essex County Health Partners*** will meet quarterly to:

- assess progress on activities,
- identify barriers to the implementation of activities, and
- develop strategies to overcome barriers and/or determine how activities may be adjusted for success.

The Lead Partner for each activity will document activities through work plan (Appendix 10) updates on a quarterly basis.

A representative of ***Essex County Health Partners*** will submit a quarterly update to NYSDOH.

Description of these Steps 3-5 of the Take Action Cycle concludes this Part III: Community Health Improvement/Service Plan (CHISP) 2019-2021 of the full report.

PART IV: DISSEMINATION PLAN

Executive Summary

PART I: Introduction

PART II: Community Health Assessment 2019

PART III: Community Health Improvement/Service Plan 2019-2021

PART IV: Dissemination Plan

Part V: Appendices

The Essex County Community Health Assessment (CHA) 2019 and (CHISP) 2019-2021 is one report with multiple Parts that will be shared broadly in its entirety, or in Parts and summaries.

Public Notification

Two methods for making the CHA/CHISP available to the public include:

1. ***Essex County Health Partners*** will post this report on their respective webpages; and
2. A joint press release of the ***Partners*** will be distributed to local news outlets.

Stakeholder Notification

Essex Health Partners will summarize findings, share information and educate their committees as to the totality of the report and how it may be used to support future health outcomes. This includes the committees engaged with the assessment and planning process.

- Public Health Advisory Committee of the Essex County Health Department
- Population Health Committee of Adirondack Health
- Population Health Committee of UVHN-Elizabethtown Community Hospital

Community-Based Committees/Coalitions Notification

Additionally, Essex County Health Department will inform and educate the following local community based committees and coalitions that are engaged with ongoing assessment and planning efforts:

- Essex County Human Service Sub-Committee of the Board of Supervisors,
- Essex County Community Services Board facilitated by the Essex County Mental Health Department
- Human Services Coalition facilitated by the Adirondack Community Action Program.

Additional Public Notification

Further dissemination may be conducted including but not limited to:

- Hospital Associations; Public Health Associations; Rural Health Associations
- Caregiver Groups; Universities and Charitable foundations; Faith-Based Organizations
- State and county extension offices; Schools; Local government; Health care providers/centers; Libraries

Appendices

The Appendices for this report are maintained as individual & separate documents.

Appendix 1 ARHN Stakeholder Survey Report

Appendix 2 ARHN Essex County Health Indicators Data Sheets

Appendix 3 ARHN Community Profile Data Sheets

Appendix 4 Collaborative Committee List

Appendix 5 Distributed Focus Group Analysis Report

Appendix 6 Community Survey Analysis Report

Appendix 7 Stakeholder Survey Analysis Report

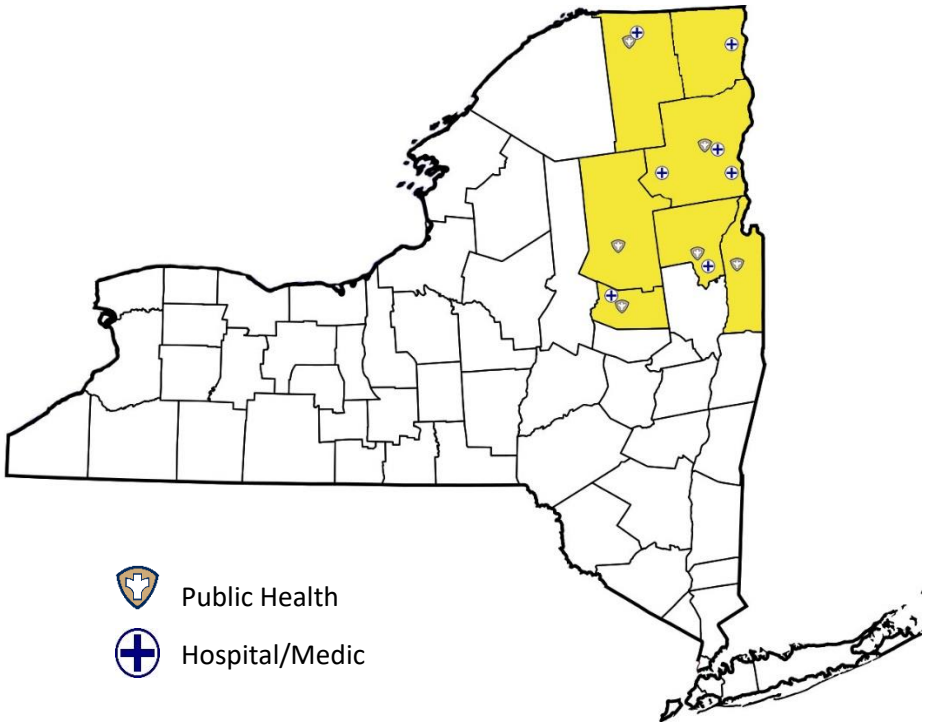
Appendix 8 Master Source List

Appendix 9 Prioritization Matrix

Appendix 10 CHISP Work Plan

Appendix 1: ARHN Stakeholder Survey Report

Summary of 2019 Community Stakeholder Survey



Adirondack Rural Health Network Service Area

Clinton, Essex, Franklin, Fulton, Hamilton,
Warren and Washington Counties

ARHN is a program of AHI-Adirondack Health Institute
Supported by the New York State Department of Health, Office of Health Systems Management, Division of Health Facility Planning, Charles D. Cook Office of Rural Health.

April 8, 2019

Background:

Adirondack Rural Health Network: The Adirondack Rural Health Network (ARHN) is a program of AHI - Adirondack Health Institute, Inc. Established in 1992 through a New York State Department of Health Rural Health Development Grant, ARHN is a multi-stakeholder, regional coalition that informs planning, assessment, provides education and training to further the implementation of the New York State Department of Health Prevention Agenda, and offers other resources that support the development of the regional health care system. Since its inception, ARHN has provided a forum to assess regional population health needs and develop collaborative responses to priorities. ARHN includes organizations from New York's Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington counties.

Description of the Community Health Assessment Committee: Since 2002, ARHN has been recognized as the leading sponsor of formal community health planning throughout the region. The Community Health Assessment (CHA) Committee, facilitated by ARHN, is made up of hospitals and county health departments that have developed and implemented a sophisticated process for community health assessment and planning for the defined region to address identified regional priorities. The CHA Committee is made up of representatives from Adirondack Health, Clinton County Health Department, University of Vermont Health Network - Alice Hyde Medical Center, University of Vermont Health Network - Elizabethtown Community Hospital, Essex County Health Department, Franklin County Public Health, Fulton County Public Health, Glens Falls Hospital, Hamilton County Public Health, Nathan Littauer Hospital, University of Vermont Health Network – Champlain Valley Physicians Hospital, Warren County Health Services, and Washington County Public Health.

Purpose of the CHA Committee: The CHA Committee, made up of the CHA service contract holders with AHI, is a multi-county, regional stakeholder group that convenes to support ongoing health planning and assessment by working collaboratively on interventions and developing the planning documents required by the New York State Department of Health and the Internal Revenue Service in an effort to advance the New York State Prevention Agenda.

CHA Committee, Ad Hoc Data Sub-Committee: At the June 15, 2018 CHA meeting, it was decided that an Ad Hoc Data Sub-Committee would be created to review tools and processes used by CHA Committee members to develop their Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP), as well as identify ways to enhance the CHA/CHIP process. A primary activity of the Ad Hoc Data Sub-Committee was to collaboratively develop a stakeholder survey.

The data subcommittee met seven times from mid-July through the end of October 2018. Meetings were held via conference call/webinar. Attendance ranged from 10 to 12 subcommittee members per meeting. Meetings were also attended by AHI staff from ARHN, Population Health Improvement Program (PHIP) and Data teams.

Survey Methodology:

Survey Creation: The 2019 Community Stakeholder Survey was drafted by the Ad Hoc Data Sub-Committee, with the final version approved by the full CHA Committee at December 7, 2018 meeting.

Survey Facilitation: ARHN surveyed stakeholders in the seven-county service area, to provide the CHA Committee with input on regional health care needs and priorities. Stakeholders included professionals from health care, social services, educational, and governmental institutions as well as community

members. The ARHN region is made up of Clinton, Essex, Franklin, Fulton, Hamilton, Warren and Washington Counties.

Survey Logistics: The survey was developed through SurveyMonkey and included 14 community health questions as well as several demographic questions. The CHA Committee provided a list of health care, social service, education, government, and service providers (hereafter referred to as community stakeholders) by county to be surveyed. The collected distribution list totaled 807 community stakeholders.

An initial email was sent to the community stakeholders in early January 2019 by the CHA Committee partners, introducing and providing a web-based link to the survey. A follow-up email was sent by ARHN staff approximately two weeks later after the initial reach out. CHA Committee members were provided the names of all non-respondents for additional follow-up, at partner discretion.

The survey requested that community stakeholders identify the top two priority areas from a list of five which they believe need to be addressed within their county. Community stakeholders also gave insight on what they felt were the top health concerns and what contributing factors were most influential for those specific health concerns. A full list of survey questions can be found under Appendix A.

Survey Responses and Analysis: A total of 409 responses were received through February 8, 2019, for a total response rate of 50.68%. Respondents were asked to indicate in which counties they provided services and could choose coverage of multiple counties, as appropriate. The total response count per county is outlined in the *By County* section. It took respondents an average of 22 minutes to complete the survey, with a median response time of approximately 17 minutes.

Analysis is sorted alphabetically and in order of how the questions were listed in the survey to make the analysis easier to comprehend. Each table is labeled to identify whether the information is by response count or percentage. For tables containing counties, the table below indicates table is color coded to identify counties . All written analysis for each section is provided, with table below, and all written results are done in percentages.

This report provides a regional look at the results thru a wide-angle lens, focusing on the Adirondack Rural Health Network (ARHN) service area. It provides individual analyses of Clinton, Essex, Franklin, Fulton, Hamilton, Warren and Washington counties. This stakeholder survey was conducted to gather information from a variety of fields and perspectives to provide valuable insight into the community's needs. The results enable us to guide strategic planning throughout the Adirondack region, for partners who serve individual counties, and those whose footprint covers multiple counties.

Clinton
Essex
Franklin
Fulton
Hamilton
Warren
Washington

Summary Analysis

1. Indicate county/counties served

Respondents were asked which county their organization/agency serves. Over 68% of respondents were from Essex and Washington counties. Approximately 16% of respondents listed the county they serve as outside of the seven ARHN counties, including Montgomery, Saratoga and St. Lawrence counties. Twelve percent of respondents identified themselves as serving the Adirondack/North Country region as a whole.

It should be noted that the figures below may not add up to 100%, due to organizations with multiple county coverage areas.

Respondents by County		
County/Region	**Total Response Count**	**Total Response Percentage**
Adirondack/North Country Region	49	12.04%
Clinton	81	19.90%
Essex	129	31.70%
Franklin	82	20.15%
Fulton	50	12.29%
Hamilton	69	16.95%
Warren	92	22.60%
Washington	150	36.86%
Other	65	15.97%

*Figures do not add up to 100% due to multiple counties per organization.

2. Indicate the community sector that best describes your organization

Community stakeholders were asked to indicate one community sector that best described their organization or agency. Over 160 organizations responded to the survey, spanning multiple counties in the ARHN region. Respondents provided a wide range of services, including *Education (19.0%)*, *Health Care (13.2%), Social Services (12.5%), Public Health (9.2%), and Health Based Community Based Organizations (CBO) (7.5%),* among many others.

Response Counts by Community Sector	
Community Sector	**Total**
Business	4
Civic Association	3
College/University	7
Disability Services	10
Early Childhood	9
Economic Development	6
Employment/Job Training	2
Faith-Based	3
Food/Nutrition	10
Foundation/Philanthropy	1
Health Based CBO	30
Health Care Provider	53

Health Insurance Plan	1
Housing	7
Law Enforcement/Corrections and Fire Department	10
Local Government (e.g. elected official, zoning/planning board)	29
Media	2
Mental, Emotional, Behavioral Health Provider	22
Public Health	37
Recreation	3
School (K – 12)	69
Seniors/Elderly	28
Social Services	50
Transportation	2
Tribal Government	1
Veterans	2

3. Indicate your job title

Approximately 42.64% of respondents listed themselves as an *Administrator or Director.* There was a significant number of respondents who identified their title as Other (22.69%). Of those responses, the majority included teachers or education professionals and program coordinators.

It's important to note that based off responses, there did not seem to be enough answer choices. Moving forward, a recommendation would be to broaden answer choices to incorporate more community stakeholders.

Respondent Job Titles		
Job Title	**Responses**	
	Count	**Percentage**
Community Member	5	1.25%
Direct Service Staff	94	23.44%
Program/Project Manager	40	9.98%
Administrator/Director	171	42.64%
Other	91	22.69%

4. NYS Prevention Agenda Priority Areas

Top Priority Area for the ARHN Region:

Survey participants were asked to rank the NYS Prevention Agenda Priority Areas in order of most to least impact. Overall, respondents in the ARHN region identified *Promote Well-Being and Prevent Mental and Substance Use Disorders* (41.7%) as their top priority, followed by *Promote a Healthy and Safe Environment* (21.9%).

NYS Prevention Agenda Top Priority Area for the ARHN Region		
County	**First Choice**	**Second Choice**
ARHN Region	Promote Well-Being and Prevent Mental and Substance Use Disorders	Promote a Healthy and Safe Environment

Top Priority Area by County:

To analyze the chosen priority areas, responses were totaled per county and the priority area that received the most responses is listed as the *First Choice*, followed by the second most responses listed as *Second Choice.*

All seven of the ARHN counties identified *Promote Well-Being and Prevent Mental and Substance Use Disorders* as their top priority. Additionally, Clinton, Essex, Franklin and Fulton counties identified *Prevent Chronic Disease* as their second choice while Clinton, Essex, Warren and Washington counties identified *Promote a Healthy and Safe Environment* as their second choice. Clinton and Essex counties have an overlap due to ties.

As survey participants were not provided focus areas or goals associated with each priority area, it can be assumed that the answers for these priority areas were slightly swayed due to what partners believe *Promote Well-Being and Prevent Mental and Substance Use Disorders* represents or what they feel would be listed in that category.

NYS Prevention Agenda Top Priority Area by County		
County	**First Choice**	**Second Choice**
Clinton	Promote Well-Being and Prevent Mental and Substance Use Disorders	Tie: • Prevent Chronic Disease • Promote a Healthy and Safe Environment
Essex	Promote Well-Being and Prevent Mental and Substance Use Disorders	Promote Healthy Women, Infants and Children
Franklin	Promote Well-Being and Prevent Mental and Substance Use Disorders	Prevent Chronic Disease
Fulton	Promote Well-Being and Prevent Mental and Substance Use Disorders	Prevent Chronic Disease
Hamilton	Promote Well-Being and Prevent Mental and Substance Use Disorders	Tie: • Prevent Chronic Disease • Promote a Healthy and Safe Environment
Warren	Promote Well-Being and Prevent Mental and Substance Use Disorders	Promote a Healthy and Safe Environment
Washington	Promote Well-Being and Prevent Mental and Substance Use Disorders	Promote a Healthy and Safe Environment

*Overlapping in county choices is due to several ties in response totals.

5. In your opinion, what are the top five health concerns affecting the residents of the counties your organization/agency serves?

Health Concerns for the ARHN Region:

Community stakeholders were asked to choose what they believed to be the top five health concerns affecting the residents in the counties their organization/agency served. The choices were ranked from one, being the highest health concern, to five, indicating the lowest health concern.

Survey respondents felt that the top five health concerns affecting the residents within the ARHN region were *Mental Health (16.9%), Substance Abuse (12.3%), Opioid Use (9.5%), Overweight/Obesity (8.8%),* and *Child/Adolescent Emotional Health (5.7%).*

Response Counts for ARHN Region Health Concerns					
ARHN Region Health Concerns	**1 (Highest)**	**2**	**3**	**4**	**5 (Lowest)**
Adverse Childhood Experiences	20	20	19	13	8
Alzheimer's Disease/Dementia	19	17	8	5	9
Arthritis	1	0	2	3	1
Autism	2	2	2	2	4
Cancers	13	14	19	7	8
Child/Adolescent Physical Health	13	12	10	13	8
Child/Adolescent Emotional Health	20	36	20	22	14
Diabetes	10	14	14	6	16
Disability	4	7	5	5	11
Dental Health	1	5	5	10	14
Domestic Abuse/Violence	4	7	16	18	10
Drinking Water Quality	0	1	1	2	5
Emerging Infectious Diseases	2	1	5	1	8
Exposure to Air and Water Pollutants/Hazardous Materials	1	0	1	0	1
Falls	3	7	5	3	4
Food Safety	3	1	2	3	2
Heart Disease	7	11	9	16	12
Hepatitis C	0	0	1	2	1
High Blood Pressure	1	2	8	6	8
HIV/AIDS	0	0	1	0	2
Hunger	4	10	5	6	5
Infant Health	1	0	8	1	4
Infectious Disease	1	0	2	3	4
LGBT Health	0	1	0	1	2
Maternal Health	3	4	3	3	7
Mental Health Conditions	59	48	36	37	23
Motor Vehicle Safety (impaired/distracted driving)	0	0	1	0	7
Opioid Use	33	18	16	14	11
Overweight or Obesity	31	25	26	23	17
Pedestrian/Bicyclist Accidents	0	0	0	0	2
Prescription Drug Abuse	4	7	11	9	7
Respiratory Disease (asthma, COPD, etc.)	5	10	5	9	8

Senior Health	18	9	12	13	11
Sexual Assault/Rape	2	0	0	3	3
Sexually Transmitted Infections	2	0	0	4	4
Social Connectedness	2	4	9	18	16
Stroke	0	2	2	1	2
Substance Abuse	43	33	38	29	10
Suicide	1	5	2	2	7
Tobacco Use/Nicotine Addiction (smoking, vaping, chewing, etc.)	11	7	11	19	27
Underage Drinking/Excessive Adult Drinking	2	8	5	6	5
Unintended/Teen Pregnancy	2	1	1	4	10
Violence (assault, firearm related)	1	0	1	2	5

Health Concerns by County:

Overall, most of the health concerns identified per county aligned with the top five health concerns identified for the ARHN region. Several counties recognized health concerns outside the top five for the ARHN region. Three out of the seven ARHN counties listed *Adverse Childhood Experiences* as a top health concern in their county.

Warren and Washington county respondents felt that *Alzheimer's Disease* was a concern in their area, while Clinton and Hamilton counties included *Heart Disease* as a concern for their counties. Outliers include Hamilton County listing *Diabetes* and Fulton County listing *Tobacco Use* as a top concern in their county.

Top Five Health Concerns by County					
County	**1st**	**2nd**	**3rd**	**4th**	**5th**
Clinton	Mental Health Conditions	Overweight/Obesity	Opioid Use	Senior Health	Heart Disease
Essex	Substance Abuse	Mental Health Conditions	Child/Adolescent Emotional Health	Overweight/Obesity	Adverse Childhood Experiences
Franklin	Mental Health Conditions	Overweight/Obesity	Substance Abuse	Opioid Use	Adverse Childhood Experiences
Fulton	Mental Health Conditions	Substance Abuse	Tobacco Use	Opioid Use	Child/Adolescent Emotional Health
Hamilton	Substance Abuse	Mental Health Conditions	Overweight/Obesity	Heart Disease	Diabetes
Warren	Mental Health Conditions	Overweight/Obesity	Adverse Childhood Experiences	Substance Abuse	Alzheimer's Disease
Washington	Substance Abuse	Mental Health Conditions	Opioid Use	Alzheimer's Disease	Cancers

6. In your opinion, what are the top five contributing factors to the health concerns you chose in the previous question, affecting the residents of the counties your organization/agency serves?

Respondents were asked to identify what they believed to be the top five contributing factors to the health concerns they chose. The contributing factors were ranked from one to five, with one being the highest contributing factor and five being the lowest.

Contributing Factors for the ARHN Region:

The top five contributing factors identified by survey respondents are *Poverty (12.7%), Addiction to illicit drugs (10.9%), Changing family structures (10.6%), Lack of mental health services (10.3%), and Age of residents (8.3%).* Forty-four percent of respondents chose these factors as either the highest or second highest contributing factors for the health concerns that they had previously identified.

Response Counts for Top Contributing Factors in the ARHN Region					
ARHN Region Contributing Factors	**1 (Highest)**	**2**	**3**	**4**	**5 (Lowest)**
Addiction to alcohol	14	16	12	7	6
Addiction to illicit drugs	37	36	22	13	5
Addiction to nicotine	7	10	6	7	11
Age of residents	28	11	6	4	7
Changing family structures (increased foster care, grandparents as parents, etc.)	36	22	15	20	8
Crime/violence/community blight	0	1	2	1	4
Deteriorating infrastructure (roads, bridges, water systems, etc.)	1	0	1	0	3
Discrimination/racism	0	0	0	0	1
Domestic violence and abuse	4	6	5	4	7
Environmental quality	0	3	4	5	6
Excessive screen time	2	13	11	4	8
Exposure to tobacco smoke/emissions from electronic vapor products	1	3	5	1	3
Food insecurity	8	13	9	8	7
Health care costs	16	17	21	20	16
Homelessness	1	2	4	4	2
Inadequate physical activity	5	16	15	17	21
Inadequate sleep	0	0	2	3	3
Inadequate/unaffordable housing options	5	9	16	8	13
Lack of chronic disease screening, treatment and self-management services	3	8	7	7	4
Lack of cultural and enrichment programs	1	2	1	1	3
Lack of dental/oral health care services	1	3	0	6	7
Lack of educational opportunities for people of all ages	1	2	3	2	9
Lack of educational, vocational or job-training options for adults	1	1	0	6	1
Lack of employment options	1	3	12	7	7
Lack of health education programs	3	1	4	3	2
Lack of health insurance	3	1	4	3	3
Lack of intergenerational connections within communities	1	0	2	4	8
Lack of mental health services	35	28	27	26	9
Lack of opportunities for health for people with physical limitations or disabilities	2	0	1	4	4

Lack of preventive/primary health care services (screenings, annual check-ups)	6	5	2	3	3
Lack of social supports for community residents	4	3	10	8	9
Lack of specialty care and treatment	1	4	4	3	2
Lack of substance use disorder services	8	8	11	4	6
Late or no prenatal care	0	0	1	2	3
Pedestrian safety (roads, sidewalks, buildings, etc.)	0	0	0	0	1
Poor access to healthy food and beverage options	5	2	6	9	0
Poor access to public places for physical activity and recreation	2	3	1	3	4
Poor educational attainment	2	8	2	8	8
Poor community engagement and connectivity	6	5	4	6	14
Poor eating/dietary practices	12	15	15	17	12
Poor health literacy (ability to comprehend health information)	6	2	4	5	4
Poor referrals to health care, specialty care, & community-based support services	8	5	4	4	7
Poverty	43	18	16	16	23
Problems with Internet access (absent, unreliable, unaffordable)	0	0	0	3	2
Quality of schools	0	0	1	1	3
Religious or spiritual values	0	0	0	1	1
Shortage of child care options	0	1	3	1	3
Stress (work, family, school, etc.)	7	10	15	21	9
Transportation problems (unreliable, unaffordable)	9	13	15	13	14
Unemployment/low wages	3	6	3	8	13

Contributing Factors by County:

The majority of the ARHN counties identified contributing factors that fell in line with the overall ARHN region's top five. Another contributing factor indicated by Franklin, Hamilton and Warren counties was *Health Care Costs*.

Top Five Contributing Factors by County					
County	**1st**	**2nd**	**3rd**	**4th**	**5th**
Clinton	Poverty	Food Insecurity	Addiction to Illicit Drugs	Lack of Mental Health Services	Inadequate Physical Activity
Essex	Poverty	Lack of Mental Health Services	Changing Family Structures	Addiction to Illicit Drugs	Age of Residents
Franklin	Poverty	Lack of Mental Health Services	Addiction to Illicit Drugs	Changing Family Structures	Health Care Costs
Fulton	Lack of Mental Health Services	Poverty	Poor Eating/ Dietary Practices	Changing Family Structures	Addiction to Illicit Drugs
Hamilton	Age of Residents	Health Care Costs	Lack of Mental Health Services	Poverty	Poor Community Engagement and Connectivity
Warren	Age of Residents	Lack of Mental Health Services	Changing Family Structures	Health Care Costs	Poverty
Washington	Addiction to Illicit Drugs	Age of Residents	Poverty	Lack of Mental Health Services	Changing Family Structures

8. Please rank the following Social Determinants of Health impacting the residents of the counties that your organization/agency serves using a scale of (1) "excellent" to (5) "very poor".

This survey question asked respondents to rank the Social Determinants of Health, listed below, in order from one, excellent, to five, very poor. The table below encompasses response counts for the entire survey.

Many respondents chose *Health and Health Care (29.0%)* as the social determinant of health that they felt most impacted the residents of the counties that they serve, followed by *Economic Stability (22.4%).* Both of these specific Social Determinants of Health align with the chosen health factors and contributing factors listed previously.

Response Counts per Social Determinants of Health Ranking					
Social Determinants of Health	**1 (Excellent)**	**2**	**3**	**4**	**5 (Very Poor)**
Economic Stability (consider poverty, employment, food security, housing stability)	54	22	33	53	100
Education (consider high school graduation, enrollment in higher education, language and literacy, early childhood education and development)	50	67	66	49	27
Health and Health Care (consider access to primary care, access to specialty care, health literacy)	70	64	79	52	49
Neighborhood and Built Environment (consider access to healthy foods and beverages, quality of housing, crime and violence, environmental conditions, transportation)	35	67	61	79	43
Social and Community Context (consider social cohesion, civic participation, perceptions of discrimination and equity, incarceration/institutionalization)	32	58	73	62	38

9. In your opinion, what population in the counties your organization/agency serves experiences the poorest health outcomes?

To help determine who the target audience that has the greatest need is, we asked, in their opinion, what population, in the counties they serve, experiences the poorest health outcomes.

Every county in the ARHN region chose *Individuals living at or near the federal poverty level (33.3%)* as the population they felt had the poorest health outcomes. For six of the seven ARHN counties, excluding Hamilton, the second population with the highest responses was *Individuals with mental health issues (24.3%).* For Hamilton County, the second population believed to have the poorest health outcomes were *Seniors or Elderly (1.8%).*

Response Counts for Poorest Health Outcomes by County							
Population	**Clinton**	**Essex**	**Franklin**	**Fulton**	**Hamilton**	**Warren**	**Washington**
Children/Adolescents	0	5	1	1	2	5	4
Females of reproductive age	0	0	0	0	0	0	0
Individuals living at or near the federal poverty level	35	46	32	14	19	25	39
Individuals living in rural areas	5	6	7	2	8	12	17
Individuals with disability	1	2	0	0	0	1	0

Individuals with mental health issues	19	24	19	11	9	14	29
Individuals with substance abuse issues	2	8	4	1	6	7	16
Migrant workers	1	1	1	0	0	0	0
Seniors/Elderly	5	7	6	6	10	8	17
Specific racial or ethnic groups	0	0	0	0	0	0	0
Other (please specify)	0	1	0	1	1	1	2
Total per county	**68**	**101**	**70**	**37**	**56**	**74**	**126**

10. New York State Prevention Agenda Goals

Top Three Goals for the ARHN Region:

Respondents were asked to choose three goals that their organization could assist in achieving in their counties. The top three goals for each NYS Prevention Agenda priority area aligned with most of the individual county goals.

Top Three Prevention Agenda Goals for the ARHN Region			
NYS Prevention Agenda Priority Areas	**Goal #1**	**Goal #2**	**Goal #3**
Prevent Chronic Disease	Increase skills and knowledge to support healthy food and beverage choices	Improve self-management skills for individuals with chronic disease	Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities
Promote Healthy Women, Infants and Children	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations
Promote a Healthy and Safe Environment	Promote healthy home and schools' environments	Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change	Reduce violence by targeting prevention programs to highest risk populations
Promote Well-Being and Prevent Mental and Substance Use Disorders	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent opioid and other substance misuse and deaths
Prevent Communicable Disease	Improve vaccination rates	Improve infection control in health care facilities	Reduce inappropriate antibiotic use

Top Three Goals by County:

To align with the structure of the survey, county analysis is provided per NYS Prevention Agenda priority area.

Prevent Chronic Disease

Most of the responses contained two specific goals, *Promote the use of evidence-based care to manage chronic diseases* and *Improve self-management skills for individuals with chronic disease.* Five out of the seven ARHN counties also listed *Promote tobacco use cessation*. Washington County was the only county to include *Improving community environments that support active transportation,* which aligns with the top ARHN goals.

Priority Area: Prevent Chronic Disease			
County/Region	**Goal #1**	**Goal #2**	**Goal #3**
Clinton	Improve self-management skills for individuals with chronic disease	Promote school, child care, and worksite environments that support physical activity for people of all ages and abilities	Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use
Essex	Improve self-management skills for individuals with chronic disease	Promote school, child care, and worksite environments that support physical activity for people of all ages and abilities	Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use
Franklin	Improve self-management skills for individuals with chronic disease	Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use	Promote the use of evidence-based care to manage chronic diseases
Fulton	Improve self-management skills for individuals with chronic disease	Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use	Increase skills and knowledge to support healthy food and beverage choices
Hamilton	Improve self-management skills for individuals with chronic disease	Promote the use of evidence-based care to manage chronic diseases	Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use
Warren	Improve self-management skills for individuals with chronic disease	Increase skills and knowledge to support healthy food and beverage choices	Promote the use of evidence-based care to manage chronic diseases
Washington	Improve self-management skills for individuals with chronic disease	Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities.	Increase skills and knowledge to support healthy food and beverage choices

Promote Healthy Women, Infants and Children

All ARHN counties choose *Support and enhance children and adolescents' social-emotional development and relationships* as their number one goal. Clinton, Fulton, Hamilton, Warren and Washington counties also listed *Reduce racial, ethnic, economic and geographic disparities in maternal and child health outcomes* as one of their top three goals.

Priority Area: Promote Healthy Women, Infants and Children			
County/Region	**Goal #1**	**Goal #2**	**Goal #3**
Clinton	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations
Essex	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Increase supports for children with special health care needs
Franklin	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Increase supports for children with special health care needs
Fulton	Support and enhance children and adolescents' social-emotional development and relationships	Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations	Increase supports for children with special health care needs
Hamilton	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations
Warren	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations
Washington	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations

Promote a Healthy and Safe Environment

Promote healthy home and schools' environments was chosen as the top goal for all seven of the ARHN counties, as well as the ARHN region as a whole. *Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change* was also listed in the top three goals for every county.

Priority Area: Promote a Healthy and Safe Environment			
County/Region	**Goal #1**	**Goal #2**	**Goal #3**
Clinton	Promote healthy home and schools' environments	Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change	Reduce falls among vulnerable populations
Essex	Promote healthy home and schools' environments	Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change	Reduce violence by targeting prevention programs to highest risk populations
Franklin	Promote healthy home and schools' environments	Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change	Reduce violence by targeting prevention programs to highest risk populations
Fulton	Promote healthy home and schools' environments	Reduce violence by targeting prevention programs to highest risk populations	Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change
Hamilton	Promote healthy home and schools' environments	Reduce falls among vulnerable populations	Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change
Warren	Promote healthy home and schools' environments	Reduce falls among vulnerable populations	Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change
Washington	Promote healthy home and schools' environments	Reduce falls among vulnerable populations	Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change

Promote Well-Being and Prevent Mental and Substance Use Disorders

Strengthen opportunities to promote well-being and resilience across the lifespan and *Facilitate supportive environments that promote respect and dignity for all ages* were both within the top three goals for every county. Five counties also listed *Prevent opioid and other substance misuse and deaths* in their top three goals.

Priority Area: Promote Well-Being and Prevent Mental and Substance Use Disorders			
County/Region	**Goal #1**	**Goal #2**	**Goal #3**
Clinton	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent opioid and other substance misuse and deaths
Essex	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent opioid and other substance misuse and deaths
Franklin	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent opioid and other substance misuse and deaths
Fulton	Prevent opioid and other substance misuse and deaths	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages
Hamilton	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent and address adverse childhood experiences
Warren	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent and address adverse childhood experiences
Washington	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent opioid and other substance misuse and deaths

Prevent Communicable Diseases

All seven ARHN counties listed *Improve vaccination rates, Improve infection control in health care facilities,* and *Reduce inappropriate antibiotic use* in the top three goals that their organization can assist in improving. *Reduce the annual growth rate for Sexually Transmitted Infections (STIs)* was also included in Fulton County's top three goals.

Priority Area: Prevent Communicable Disease			
County/Region	**Goal #1**	**Goal #2**	**Goal #3**
Clinton	Improve vaccination rates	Improve infection control in health care facilities	Reduce inappropriate antibiotic use
Essex	Improve vaccination rates	Reduce inappropriate antibiotic use	Improve infection control in health care facilities
Franklin	Improve vaccination rates	Improve infection control in health care facilities	Reduce inappropriate antibiotic use
Fulton	Improve vaccination rates	Reduce inappropriate antibiotic use	Reduce the annual growth rate for Sexually Transmitted Infections (STIs)
Hamilton	Reduce inappropriate antibiotic use	Improve vaccination rates	Improve infection control in health care facilities
Warren	Improve vaccination rates	Improve infection control in health care facilities	Reduce inappropriate antibiotic use
Washington	Improve vaccination rates	Improve infection control in health care facilities	Reduce inappropriate antibiotic use

12. Based on the goals you selected, please identify the resources your organization/agency can contribute toward achieving these goals.

Respondents were asked to indicate the resources that their organization/agency would be able to contribute toward achieving the goals they listed. The table below encompasses the top ten resources listed.

Approximately 70% of all respondents identified *Participating on committees, workgroups and coalitions* and *Share knowledge of community resources* as the main resources they can contribute to help achieve the NYS Prevention Agenda goals listed above. Respondents also felt strongly that they can deliver education and counseling and provide expertise relevant to achieving the listed goals.

This is the first year that we have asked this question in the stakeholder survey. This would be a helpful resource to explore further once partners begin exacting their approved plans.

Response Counts and Percentages for Resources Organizations Can Contribute		
Resources	**Count**	**Percentage**
Participate on committees, work groups, coalitions to help achieve the selected goals	208	70.99%
Share knowledge of community resources	204	69.62%
Deliver education and counseling relevant to the selected goal(s)	189	64.51%
Provide subject-matter knowledge and expertise	182	62.12%
Promote health improvement activities/events through social media and other communication channels your organization/agency operates	164	55.97%
Facilitate access to populations your organization/agency serves	139	47.44%

Provide letters of support for planned health improvement activities	124	42.32%
Offer health related-educational materials	117	39.93%
Facilitate access to committees, work groups, coalitions currently working to achieve the selected goals	112	38.23%
Work to promote changes to policies/laws/community environment to address selected goal(s)	111	37.88%

Appendix A. 2019 Stakeholder Survey

2019 CHA Stakeholders Survey

Introduction

To help inform a collaborative approach to improving community health, the Adirondack Rural Health Network (ARHN) seeks to identify priorities, factors and resources that influence the health of residents of the Adirondack region (Clinton, Essex, Franklin, Fulton, Hamilton, Warren and Washington counties).

You have been identified as a key informant who can provide insight into health and well-being of the people your organization/agency serves. Please answer the survey questions in the context of your role within your organization/agency and in representing the population(s) your organization/agency serves.

All survey information will be held confidential and no responses will be attributed to any one individual or agency.

Your Organization/Agency

Please provide the following information about your organization/agency and yourself:

1. Organization/Agency name:

2. Your name (Please provide first and last name):

3. Your job title/role:

- ☐ Community Members
- ☐ Direct Service Staff
- ☐ Program/Project Manager
- ☐ Administrator/Director
- ☐ Other (please specify)

4. Your email address:

5. Indicate the **one** community sector that best describes your organization/agency:

- ☐ Business
- ☐ Civic Association
- ☐ College/University
- ☐ Disability Services

- ☐ Early Childhood
- ☐ Economic Development
- ☐ Employment/Job training
- ☐ Faith-Based
- ☐ Food/Nutrition
- ☐ Foundation/Philanthropy
- ☐ Health Based CBO
- ☐ Health Care Provider
- ☐ Health Insurance Plan
- ☐ Housing
- ☐ Law Enforcement/Corrections
- ☐ Local Government (e.g. elected official, zoning/planning board)
- ☐ Media
- ☐ Mental, Emotional, Behavioral Health Provider
- ☐ Public Health
- ☐ Recreation
- ☐ School (K – 12)
- ☐ Seniors/Elderly
- ☐ Social Services
- ☐ Transportation
- ☐ Tribal Government
- ☐ Veterans
- ☐ Other (please specify):

6. Indicate the counties your organization/agency serves. **Check all that apply.**

- ☐ Adirondack/North Country Region
- ☐ Clinton
- ☐ Essex
- ☐ Franklin
- ☐ Fulton
- ☐ Hamilton
- ☐ Warren
- ☐ Washington
- ☐ Other: _____

Health Priorities, Concerns and Factors

The NYS Prevention Agenda for 2019-2024 identifies five main priority areas that are key to improving the health of residents that you serve. These main priority areas are listed in question #7.

7. Please rank, **by indicating 1 through 5**, the priority areas that, if addressed locally, would have the greatest to the smallest impact on improving the health and well-being of the residents of the counties your organization/agency serves. (#1 ranked priority area would have the most impact; #5 ranked priority area would have the least impact.)

- ☐ Prevent Chronic Diseases
- ☐ Promote Healthy Women, Infants and Children
- ☐ Prevent Communicable Diseases
- ☐ Promote a Healthy and Safe Environment
- ☐ Promote Well-Being and Prevent Mental and Substance Use Disorders

8. In your opinion, what are the **top five (5) health concerns** affecting the residents of the counties your organization/agency serves? Please rank the health concerns from 1 (highest) to 5 (lowest).

- ☐ Adverse childhood experiences
- ☐ Alzheimer's disease/Dementia
- ☐ Arthritis
- ☐ Autism
- ☐ Cancers
- ☐ Child/Adolescent physical health
- ☐ Child/Adolescent emotional health
- ☐ Diabetes
- ☐ Disability
- ☐ Dental health
- ☐ Domestic abuse/violence
- ☐ Drinking water quality
- ☐ Emerging infectious diseases (ebola, zika virus, tick and mosquito-transmitted, etc.)
- ☐ Exposure to air and water pollutants/hazardous materials
- ☐ Falls
- ☐ Food safety
- ☐ Heart disease
- ☐ Hepatitis C
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Hunger
- ☐ Infant health
- ☐ Infectious disease
- ☐ LGBT health

- ☐ Maternal health
- ☐ Mental health conditions
- ☐ Motor vehicle safety (impaired/distracted driving)
- ☐ Opioid use
- ☐ Overweight or obesity
- ☐ Pedestrian/bicyclist accidents
- ☐ Prescription drug abuse
- ☐ Respiratory disease (asthma, COPD, etc.)
- ☐ Senior health
- ☐ Sexual assault/rape
- ☐ Sexually transmitted infections
- ☐ Social connectedness
- ☐ Stroke
- ☐ Substance abuse
- ☐ Suicide
- ☐ Tobacco use/nicotine addiction – smoking/vaping/chewing
- ☐ Underage drinking/excessive adult drinking
- ☐ Unintended/Teen pregnancy
- ☐ Violence (assault, firearm related)
- ☐ Other (Please specify):

9. In your opinion, what are the **top five** (**5**) **contributing factors** to the health concerns you chose in question #8? Please rank the contributing factors from 1 (highest) to 5 (lowest).

- ☐ Addiction to alcohol
- ☐ Addiction to illicit drugs
- ☐ Addiction to nicotine
- ☐ Age of residents
- ☐ Changing family structures (increased foster care, grandparents as parents, etc.)
- ☐ Crime/violence/community blight
- ☐ Deteriorating infrastructure (roads, bridges, water systems, etc.)
- ☐ Discrimination/racism
- ☐ Domestic violence and abuse
- ☐ Environmental quality
- ☐ Excessive screen time
- ☐ Exposure to tobacco smoke/emissions from electronic vapor products
- ☐ Food insecurity
- ☐ Health care costs
- ☐ Homelessness
- ☐ Inadequate physical activity
- ☐ Inadequate sleep
- ☐ Inadequate/unaffordable housing options
- ☐ Lack of chronic disease screening, treatment and self-management services

- ☐ Lack of cultural and enrichment programs
- ☐ Lack of dental/oral health care services
- ☐ Lack of educational opportunities for people of all ages
- ☐ Lack of educational, vocational or job-training options for adults
- ☐ Lack of employment options
- ☐ Lack of health education programs
- ☐ Lack of health insurance
- ☐ Lack of intergenerational connections within communities
- ☐ Lack of mental health services
- ☐ Lack of opportunities for health for people with physical limitations or disabilities
- ☐ Lack of preventive/primary health care services (screenings, annual check-ups)
- ☐ Lack of social supports for community residents
- ☐ Lack of specialty care and treatment
- ☐ Lack of substance use disorder services
- ☐ Late or no prenatal care
- ☐ Pedestrian safety (roads, sidewalks, buildings, etc.)
- ☐ Poor access to healthy food and beverage options
- ☐ Poor access to public places for physical activity and recreation
- ☐ Poor educational attainment
- ☐ Poor community engagement and connectivity
- ☐ Poor eating/dietary practices
- ☐ Poor health literacy (ability to comprehend health information)
- ☐ Poor referrals to health care, specialty care, and community-based support services
- ☐ Poverty
- ☐ Problems with Internet access (absent, unreliable, unaffordable)
- ☐ Quality of schools
- ☐ Religious or spiritual values
- ☐ Shortage of child care options
- ☐ Stress (work, family, school, etc.)
- ☐ Transportation problems (unreliable, unaffordable)
- ☐ Unemployment/low wages
- ☐ Other (please specify)

Social Determinants of Health

10. Social Determinants of Health are conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes. Please rate the following Social Determinants of Health impacting the residents of the counties that your organization/agency serves using a scale of (1) "very poor" to (5) "excellent".

- ☐ **Economic Stability** (consider poverty, employment, food security, housing stability)

- ☐ **Education** (consider high school graduation, enrollment in higher education, language and literacy, early childhood education and development)

- ☐ **Social and Community Context** (consider social cohesion, civic participation, perceptions of discrimination and equity, incarceration/institutionalization)

- ☐ **Neighborhood and Built Environment** (consider access to healthy foods and beverages, quality of housing, crime and violence, environmental conditions, transportation)

- ☐ **Health and Health Care** (consider access to primary care, access to specialty care, health literacy)

11. In your opinion, what **population** in the counties your organization/agency serves experiences the poorest health outcomes? Please select **<u>one</u>** population.

- ☐ Specific racial or ethnic groups
- ☐ Children/adolescents
- ☐ Females of reproductive age
- ☐ Seniors/elderly
- ☐ Individuals with disability
- ☐ Individuals living at or near the federal poverty level
- ☐ Individuals with mental health issues
- ☐ Individuals living in rural areas
- ☐ Individuals with substance abuse issues
- ☐ Migrant workers
- ☐ Others (please specify):

Improving Health and Well-Being

The NYS Prevention Agenda 2019-2024 identifies specific goals for improving the health of New Yorkers of all ages. New York State envisions that improving the health of all New Yorkers requires strategies that can be implemented by a diverse set of health and non-health organizations and agencies.

12. Over the next 5 questions, select the top 3 goals your organization/agency can assist in achieving in the counties it serves.

13. Prevent Chronic Diseases

- ☐ Increase access to healthy and affordable food and beverages
- ☐ Increase skills and knowledge to support healthy food and beverage choices
- ☐ Increase food security
- ☐ Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities
- ☐ Promote school, child care, and worksite environments that support physical activity for people of all ages and abilities
- ☐ Increase access, for people of all ages and abilities, to safe indoor and/or outdoor places for physical activity
- ☐ Prevent initiation of tobacco use, including combustible tobacco and vaping products by youth and young adults
- ☐ Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use including: low income; frequent mental distress/substance use disorder; LGBT; and disability
- ☐ Eliminate exposure to secondhand smoke and exposure to secondhand aerosol/emissions from electronic vapor products
- ☐ Increase screening rates for breast, cervical, and colorectal cancer
- ☐ Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity
- ☐ Promote the use of evidence-based care to manage chronic diseases
- ☐ Improve self-management skills for individuals with chronic disease

14. Promote Healthy Women, Infants, and Children

- ☐ Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age
- ☐ Reduce maternal mortality and morbidity
- ☐ Reduce infant mortality and morbidity
- ☐ Increase breastfeeding
- ☐ Support and enhance children and adolescents' social-emotional development and relationships
- ☐ Increase supports for children with special health care needs
- ☐ Reduce dental caries (cavities) among children
- ☐ Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations

15. Promote a Healthy and Safe Environment

- ☐ Reduce falls among vulnerable populations
- ☐ Reduce violence by targeting prevention programs to highest risk populations
- ☐ Reduce occupational injury and illness

- ☐ Reduce traffic-related injuries for pedestrians and bicyclists
- ☐ Reduce exposure to outdoor air pollutants
- ☐ Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change
- ☐ Promote healthy home and schools' environments
- ☐ Protect water sources and ensure quality drinking water
- ☐ Protect vulnerable waterbodies to reduce potential public health risks associated with exposure to recreational water
- ☐ Raise awareness of the potential presence of chemical contaminants and promote strategies to reduce exposure
- ☐ Improve food safety management

16. Promote Well-Being and Prevent Mental and Substance Use Disorders

- ☐ Strengthen opportunities to promote well-being and resilience across the lifespan
- ☐ Facilitate supportive environments that promote respect and dignity for people of all ages
- ☐ Prevent underage drinking and excessive alcohol consumption by adults
- ☐ Prevent opioid and other substance misuse and deaths
- ☐ Prevent and address adverse childhood experiences
- ☐ Reduce the prevalence of major depressive episodes
- ☐ Prevent suicides
- ☐ Reduce the mortality gap between those living with serious mental illness and the general population

17. Prevent Communicable Diseases

- ☐ Improve vaccination rates
- ☐ Reduce vaccination coverage disparities
- ☐ Decrease HIV morbidity (new HIV diagnoses)
- ☐ Increase HIV viral suppression
- ☐ Reduce the annual growth rate for Sexually Transmitted Infections (STIs)
- ☐ Increase the number of persons treated for Hepatitis C
- ☐ Reduce the number of new Hepatitis C cases among people who inject drugs
- ☐ Improve infection control in health care facilities
- ☐ Reduce infections caused by multidrug resistant organisms and C. difficile
- ☐ Reduce inappropriate antibiotic use

18. Based on the goals you selected in Questions 12-16, please identify the primary assets/resources your organization/agency can contribute toward achieving the goals you have selected.

- ☐ Provide subject-matter knowledge and expertise
- ☐ Provide knowledge of and/or access to potential sources of funding (grants, philanthropy)
- ☐ Facilitate access to committees, work groups, coalitions currently working to achieve the selected goals
- ☐ Participate on committees, work groups, coalitions to help achieve the selected goals
- ☐ Share knowledge of community resources (e.g. food, clothing, housing, transportation, etc.)
- ☐ Facilitate access to populations your organization/agency serves (to encourage participation in programs, provide feedback about health improvement efforts, etc.)
- ☐ Promote health improvement activities/events through social media and other communication channels your organization/agency operates
- ☐ Share program-level data to help track progress in achieving goals
- ☐ Provide in-kind space for health improvement meetings/events
- ☐ Offer periodic organizational/program updates to community stakeholders
- ☐ Provide staff time to help conduct goal-related activities
- ☐ Provide letters of support for planned health improvement activities
- ☐ Sign partnership agreements related to community level health improvement efforts
- ☐ Assist with data analysis
- ☐ Offer health related-educational materials
- ☐ Other (please specify):

19. Are you interested in being contacted at a later date to discuss the utilization of the resources you identified in Question #17?

- ☐ Yes
- ☐ No

20. Please add any other comments/recommendations you have about improving the health and well-being of the residents of the counties your organization/agency serves.

Appendix 2: ARHN Essex County Health Indicators Data Sheets

2019 Essex County Health Indicators Data Sheets

Essex County Revised: April 2019

MORTALITY	Number Per Year (If Available) One	Two	Three	Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark	Comparison to Benchmark	Quartile Ranking Q1	Q2	Q3	Q4	Quartile Score	Severity Score	Source
Focus Area: Disparities																
Prevention Agenda Indicators																
1. Percentage of Overall Premature Deaths (before age 65 years), 2016				19.1%	22.8%	22.4%	24.0%	**21.8%**	Meets/Better							Prevention Agenda Dashboard
2. Ratio of Black, Non-Hispanic Premature Deaths (Prior to Age 65) to White, Non-Hispanic Premature Deaths, '14 - 16				0.0*	1.69	2.05	1.95	**1.87**	Less than 10							Prevention Agenda Dashboard
3. Ratio of Hispanic/Latino Premature Deaths (Prior to Age 65) to White, Non-Hispanic Premature Deaths, '14 - 16				0.94+	2.12	2.16	1.87	**1.86**	Less than 10							Prevention Agenda Dashboard
4. Rate of Adult Age-Adjusted Preventable Hospitalizations per 10,000 Population (Ages 18 Plus), 2016				109.0	N/A	116.80	124.00	**122.0**	Meets/Better							Prevention Agenda Dashboard
5. Ratio of Black, Non-Hispanic Adult Preventable Age-Adjusted Hospitalizations to White, Non-Hispanic, 2016				0.0+	N/A	2.04	2.07	**1.85**	Less than 10							Prevention Agenda Dashboard
6. Ratio of Hispanic/Latino Adult Age-Adjusted Preventable Hospitalizations to White, Non-Hispanic, 2016				0.0+	N/A	1.27	1.28	**1.38**	Less than 10							Prevention Agenda Dashboard
7. Percentage of Adults (Ages 18 - 64) with Health Insurance, 2016				94.0%	N/A	N/A	91.4%	**100.0%**	Worse	X						Prevention Agenda Dashboard
8. Age-Adjusted Percentage of Adults with Regular Health Care Provider - Over 18 Years, 2016				88.5%	N/A	84.4%	82.6%	**90.8%**	Worse	X						Prevention Agenda Dashboard
Quartile Summary for Prevention Agenda Indicators										2	0	0	0	25.0%	0.0%	
Other Disparity Indicators																
1. Rate of Total Deaths per 100,000 Population, 2014-2016	362	452	414	1,065.4	990.5	**877.4**	769.8	N/A	Worse	X						Community Health Indicator Reports
2. Rate of Emergency Department Visits per 10,000 Population, 2016				4,912.1	4,866.3	**3,865.6**	4,169.1	N/A	Worse		X					Community Health Indicator Reports
3. Rate of Total Hospitalizations per 10,000 Population, 2016				708.4	1,039.9	**1,125.3**	1,154.4	N/A	Worse	X						Community Health Indicator Reports
4. Percentage of Adults (18 and Older) Who Did Not Receive Medical Care Due to Costs, 2016				6.7%	9.9%	**9.8%**	11.2%	N/A	Meets/Better							NYS Expanded Behavioral Risk Factor Surveillance System
5. Percentage of Adults (18 and Older) Who Report 14 Days or More of Poor Physical Health, 2016				15.4%	14.3%	**12.0%**	11.3%	N/A	Worse		X					NYS Expanded Behavioral Risk Factor Surveillance System
6. Percentage of Adults (18 and Older) Living with a Disability, 2016				26.8%	25.6%	**22.8%**	22.9%	N/A	Worse	X						NYS Expanded Behavioral Risk Factor Surveillance System
Quartile Summary for Other Indicators										3	2	0	0	83.3%	0.0%	
Quartile Summary for Focus Area Disparities										5	2	0	0	50.0%	0.0%	

Inj, Viol, Occ. Health	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score	Source
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4			
Focus Area: Injuries, Violence, and Occupational Health																
Prevention Agenda Indicators																
1. Rate of Hospitalizations due to Falls per 10,000 - Ages 65+, 2016				110.3	155.7	189.9	179.0	**204.6**	Meets/Better							Prevention Agenda Dashboard
2. Rate of ED Visits due to Falls for Children Ages 1 - 4 per 10,000 Population Children, 2016				569.3	523.8	408.5	397.3	**429.1**	Worse		X					Prevention Agenda Dashboard
3. Rate of Assault-Related Hospitalizations per 10,000 Population, 2016				0.0*	1.3	2.2	3.2	**4.3**	Less than 10							Prevention Agenda Dashboard
4. Ratio of Black, Non-Hispanic Assault-Related Hospitalizations to White, Non-Hispanic Assault Related Hospitalizations, 2016				N/A	N/A	6.4	6.2	**6.7**	Less than 10							Prevention Agenda Dashboard
5. Ratio of Hispanic/Latino Assault-Related Hospitalizations to White, Non-Hispanic Assault Related Hospitalizations, 2016				N/A	N/A	2.1	2.8	**2.8**	Less than 10							Prevention Agenda Dashboard
6. Ratio of Assault-Related Hospitalizations for Low-Income versus Non-Low Income Zip Codes, 2016				N/A	N/A	2.9	3.0	**2.9**	Less than 10							Prevention Agenda Dashboard
7. Rate of ED Occupational Injuries Among Working Adolescents Ages 15 - 19 per 10,000 Population, 2016				82.1	64.9	29.4	21.3	**33.0**	Worse				X			Prevention Agenda Dashboard
Quartile Summary for Prevention Agenda Indicators										0	1	0	1	28.6%	50.0%	
Other Indicators																
1. Falls hospitalization rate per 10,000 - Aged <10 years, 2016				0.0*	N/A	**6.5**	7.4	N/A	Less than 10							Community Health Indicator Reports
2. Falls hospitalization rate per 10,000 - Aged 10-14 years, 2016				0.0*	N/A	**3.6**	4.5	N/A	Less than 10							Community Health Indicator Reports
3. Falls hospitalization rate per 10,000 - Aged 15-24 years, 2016				N/A	N/A	**4.2**	4.8	N/A	Less than 10							Community Health Indicator Reports
4. Falls hospitalization rate per 10,000 - Aged 25-64 years, 2016				11.6	N/A	**17.4**	17.0	N/A	Meets/Better							Community Health Indicator Reports
5. Rate of Violent Crimes per 100,000 Population, 2017				172.6	171.8	**214.9**	355.6	N/A	Meets/Better							Division of Criminal Justice Services Index, Property, and Firearm Rates
6. Rate of Property Crimes per 100,000 Population, 2017				975.6	1,481.8	**1,479.5**	1,466.1	N/A	Meets/Better							Division of Criminal Justice Services Index, Property, and Firearm Rates
7. Rate of Total Crimes per 100,000 Population, 2017				1,148.2	1,427.1	**1,694.4**	1,821.7	N/A	Meets/Better							Division of Criminal Justice Services Index, Property, and Firearm Rates
8. Incidence Rate of Malignant Mesothelioma Cases, Ages 15 Plus, per 100,000 Population, '13-15				N/A	N/A	**1.6**	**1.3**	N/A	Less than 10							Community Health Indicator Reports
9. Rate of Pneumoconiosis Hospitalizations, Ages 15 Plus, per 100,000 Population, 2016				N/A	N/A	**8.8**	6.3	N/A	Less than 10							Community Health Indicator Reports
10. Rate of Asbestosis Hospitalizations, Ages 15 Plus, per 10,000 Population, 2016				N/A	N/A	**7.7**	5.5	N/A	Less than 10							Community Health Indicator Reports
11. Rate of Work-Related Hospitalizations, Employed Ages 16 Plus per 100,000 Individuals Employed, '14-16	19	16	15	101.8	N/A	**167.3**	133.8	N/A	Meets/Better							Community Health Indicator Reports
12. Rate of Elevated Blood Lead Levels Ages 16 Plus Employed per 100,000 Individuals Employed, '14-16	3	1	4	16.3*	17.9	**18.5**	17.3	N/A	Less than 10							Community Health Indicator Reports
13. Rate of Total Motor Vehicle Crashes per 100,000, 2017				2,779.5	2,162.0	**2,022.7**	1,558.5	N/A	Worse		X					NYS Traffic Safety Statistical Repository
14. Rate of Speed-Related Accidents per 100,000 Population, 2017				685.0	364.7	**214.2**	141.6	N/A	Worse				X			NYS Traffic Safety Statistical Repository
15. Rate of Motor Vehicle Accident Deaths per 100,000 Population, 2017				7.9	7.3	**7.1**	5.0	N/A	Worse	X						NYS Traffic Safety Statistical Repository
16. Rate of Traumatic Brain Injury Hospitalizations per 10,000 Population, 2016				2.8	N/A	**8.6**	8.3	N/A	Meets/Better							Community Health Indicator Reports
17. Rate of Unintentional Injury Hospitalizations per 10,000 Population, 2016				45.9	61.8	**68.3**	63.3	N/A	Meets/Better							Community Health Indicator Reports
18. Rate of Unintentional Injury Hospitalizations Ages 10 to 14 per 10,000 Population, 2016				N/A	N/A	**12.5**	13.6	N/A	Less than 10							Community Health Indicator Reports
19. Rate of Unintentional Injury Hospitalizations Ages 65 Plus per 10,000 Population, 2016				142.3	198.0	**239.3**	227.9	N/A	Meets/Better							Community Health Indicator Reports
20. Rate of Poisoning Hospitalizations per 10,000 Population, 2016				2.4*	N/A	**7.1**	7.2	N/A	Less than 10							Community Health Indicator Reports
Quartile Summary for Other Indicators										1	1	0	1	15.0%	33.3%	
Quartile Summary for Focus Area Injuries, Violence, and Occupational Health										1	2	0	2	18.5%	40.0%	

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Built Envt. & Water	Number Per Year (If Available) One	Two	Three	Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark	Comparison to Benchmark	Quartile Ranking Q1	Q2	Q3	Q4	Quartile Score	Severity Score	Source
Focus Area: Outdoor Air Quality																
1. Number of Days with Unhealthy Ozone, 2015-2017				N/A	N/A	21.0	N/A	**0.00**	Less than 10							Prevention Agenda Dashboard
2. Number of Days with Unhealthy Particulate Matter, 2015-2017				N/A	N/A	0.00	N/A	**0.00**	Less than 10							Prevention Agenda Dashboard
Quartile Summary for Focus Area Outdoor Air Quality										0	0	0	0	0.0%	0.0%	
Focus Area: Built Environment																
1. Percentage of the Population that Live in Jurisdictions that Adopted Climate Smart Communities Pledge, 2017				100.0%	0.0%	61.6%	35.6%	**32.0%**	Less than 10							Prevention Agenda Dashboard
2. Percentage of Commuters Who Use Alternative Modes of Transportation to Work, 2012-2016				19.7%	19.0%	22.9%	45.7%	**49.2%**	Worse			X				Prevention Agenda Dashboard
3. Percentage of Population with Low-Income and Low-Access to a Supermarket or Large Grocery Store, 2015				2.2%	6.0%	3.9%	2.3%	**2.2%**	Meets/Better							Prevention Agenda Dashboard
4. Percentage of Adults Experiencing Food Insecurity '13/14				20.9%	23.3%	**22.7%**	29.0%	N/A	Meets/Better							NYS Expanded Behavioral Risk Factor Surveillance System
5. Percentage of Adults Experiencing Housing Insecurity, 2016				29.4%	29.9%	**30.9%**	35.5%	N/A	Meets/Better							NYS Expanded Behavioral Risk Factor Surveillance System
6. Percentage of Homes in Healthy Neighborhoods Program that have Fewer Asthma Triggers During Home Revisits, 2013-2016				N/A	N/A	20.5%	N/A	**25.0%**	Meets/Better							Prevention Agenda Dashboard
Quartile Summary for Focus Area Built Environment										0	0	1	0	16.7%	100.0%	
Focus Area: Water Quality																
1. Percentage of Residents Served by Community Water Systems with Optimally Fluoridated Water, 2017				0.0%	26.9%	46.6%	70.8%	**78.5%**	Worse				X			Prevention Agenda Dashboard
Quartile Summary for Focus Area Water Quality										0	0	0	1	100.0%	100.0%	

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Obesity	Number Per Year (If Available) One	Two	Three	Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark	Comparison to Benchmark	Quartile Ranking Q1	Q2	Q3	Q4	Quartile Score	Severity Score	Source
Focus Area: Reduce Obesity in Children and Adults																
Prevention Agenda Indicators																
1. Percentage of Adults Ages 18 Plus Who are Obese, 2016				32.2%	N/A	**27.4%**	25.5%	23.2%	Worse		X					Prevention Agenda Dashboard
2. Percentage of Public School Children Who are Obese, '14 - 16				21.4%	N/A	17.3%	N/A	**16.7%**	Worse		X					Prevention Agenda Dashboard
Quartile Summary for Prevention Agenda Indicators										1	1	0	0	100.0%	0.0%	
Other Indicators																
1. Percentage of Total Students Overweight, '16-18				16.5%	17.5%	**16.5%**	N/A	N/A	Meets/Better							Student Weight Status Category Reporting System (SWSCRS) Data
2. Percentage of Elementary Students Overweight, Not Obese, '16-18				15.2%	17.0%	**15.7%**	N/A	N/A	Meets/Better							Student Weight Status Category Reporting System (SWSCRS) Data
3. Percentage of Elementary Student Obese, '16-18				18.7%	18.3%	**16.0%**	N/A	N/A	Worse	X						Student Weight Status Category Reporting System (SWSCRS) Data
4. Percentage of Middle and High School Students Overweight, Not Obese, '16-18				15.9%	18.1%	**17.4%**	N/A	N/A	Meets/Better							Student Weight Status Category Reporting System (SWSCRS) Data
5. Percentage of Middle and High School Students Obese, '16-18				26.8%	23.6%	**18.8%**	N/A	N/A	Worse		X					Student Weight Status Category Reporting System (SWSCRS) Data
6. Percentage of WIC Children Ages 2 - 4 Obese, '14-16				16.4%	15.9%	**15.2%**	13.9%	N/A	Worse	X						Community Health Indicator Reports
7. Percentage of Age Adjusted Adults (Ages 18 Plus) Overweight or Obese, 2016				68.2%	70.2%	**63.7%**	60.8%	N/A	Worse	X						NYS Expanded Behavioral Risk Factor Surveillance System
8. Percentage of Age Adjusted Adults (Ages 18 Plus) Who Participated in Leisure Activities Last 30 Days, 2016				76.6%	73.9%	**74.6%**	73.7%	N/A	Meets/Better							NYS Expanded Behavioral Risk Factor Surveillance System
9. Number of Recreational and Fitness Facilities per 100,000 Population, 2014				5.9	5.5	**18.7**	19.2	N/A	Worse			X				USDA Economic Research Service Fitness Facilities Data
10. Percentage of Age Adjusted Adults (Ages 18 Plus) with Cholesterol Check, '13/14				70.0%	79.7%	**84.8%**	84.2%	N/A	Worse	X						NYS Expanded Behavioral Risk Factor Surveillance System
11. Percentage of Adults (18 Plus) with Physician Diagnosed High Blood Pressure, '13/14				37.2%	36.0%	**33.0%**	31.7%	N/A	Worse	X						NYS Expanded Behavioral Risk Factor Surveillance System
12. Rate of Cardiovascular Disease Deaths per 100,000 Population, '14-16	124	135	103	314.1	295.6	**295.7**	272.2	N/A	Worse	X						Community Health Indicator Reports
13. Rate of Cardiovascular Premature Deaths (Ages 35 - 64) per 100,000 Population, '14-16	19	15	11	92.4	111.7	**101.0**	102.4	N/A	Meets/Better							Community Health Indicator Reports
14. Rate of Cardiovascular Pretransport Deaths per 100,000 Population, '14-16	83	71	58	183.9	165.4	**169.6**	153.2	N/A	Worse	X						Community Health Indicator Reports
15. Rate of Cardiovascular Hospitalizations per 10,000 Population, 2016				107.6	148.7	**1539.0**	149.9	N/A	Meets/Better							Community Health Indicator Reports
16. Rate of Diseases of the Heart Deaths per 100,000 Population, '14-16	105	103	82	251.6	233.2	**236.5**	220.7	N/A	Worse	X						Community Health Indicator Reports
17. Rate of Diseases of the Heart Premature Deaths (Ages 35 - 64) per 100,000 Population, '14-16	17	15	9	84.2	95.9	**82.8**	83.4	N/A	Worse	X						Community Health Indicator Reports
18. Rate of Disease of the Heart Pretransport Deaths per 100,000 Population, '14-16	73	57	44	151.0	134.0	**140.7**	131.0	N/A	Worse	X						Community Health Indicator Reports
19. Rate of Disease of the Heart Hospitalizations per 10,000 Population, 2016				76.1	103.1	**104.9**	100.3	N/A	Meets/Better							Community Health Indicator Reports
20. Rate of Coronary Heart Diseases Deaths per 100,000 Population, '14-16	80	63	55	171.8	154.9	**162.7**	168.7	N/A	Worse	X						Community Health Indicator Reports
21. Rate of Coronary Heart Diseases Premature Deaths (Ages 35 - 64) per 100,000 Population, '14-16	12	11	7	61.6	68.0	**60.5**	66.4	N/A	Worse	X						Community Health Indicator Reports
22. Rate of Coronary Heart Disease Pretransport Deaths per 100,000 Population, '14-16	55	34	34	106.7	91.1	**101.3**	105.0	N/A	Worse	X						Community Health Indicator Reports
23. Rate of Coronary Heart Disease Hospitalizations per 10,000 Population, 2016				28.1	38.6	**35.4**	35.0	N/A	Meets/Better							Community Health Indicator Reports
24. Rate of Congestive Heart Failure Deaths per 100,000, '14-16	5	14	5	20.8	17.6	**24.4**	16.5	N/A	Meets/Better							Community Health Indicator Reports
25. Rate of Congestive Heart Failure Premature Deaths (Ages 35 - 64) per 100,000 Population, '14-16	1	3	1	10.3*	4.8	**3.3**	2.5	N/A	Less than 10							Community Health Indicator Reports
26. Rate of Congestive Heart Failure Pretransport Deaths per 100,000 Population, '14-16	4	12	1	14.7	10.9	**14.5**	9.4	N/A	Worse	X						Community Health Indicator Reports
27. Rate of Congestive Heart Failure Hospitalizations per 10,000 Population, 2016				17.3	24.2	**25.6**	24.8	N/A	Meets/Better							Community Health Indicator Reports
28. Rate of Cerebrovascular (Stroke) Deaths per 100,000 Population, '14-16	12	21	14	40.8	40.2	**38.1**	31.3	N/A	Worse	X						Community Health Indicator Reports
29. Rate of Cerebrovascular (Stroke) Hospitalizations per 10,000 Population, 2016				15.7	23.8	**26.9**	25.4	N/A	Meets/Better							Community Health Indicator Reports
30. Rate of Hypertension Hospitalizations (Ages 18 Plus) per 10,000 Population, 2016				3.5	2.7	**9.4**	9.7	N/A	Meets/Better							Community Health Indicator Reports
31. Rate of Diabetes Deaths per 100,000 Population, '14-16	17	15	14	39.9	29.5	**19.8**	20.3	N/A	Worse				X			Community Health Indicator Reports

32. Rate of Diabetes Hospitalizations (Primary Diagnosis) per 10,000 Population, 2016				10.5	14.5	**15.4**	17.5	N/A	Meets/Better							Community Health Indicator Reports
33. Rate of Diabetes Hospitalizations (Any Diagnosis) per 10,000 Population, 2016				161.1	246.1	**237.2**	248.1	N/A	Meets/Better							Community Health Indicator Reports
Quartile Summary for Other Indicators										15	1	1	1	54.5%	11.1%	
Quartile Summary for Focus Area Reduce Obesity in Children and Adults										16	2	1	1	57.1%	10.0%	

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Smoke Exposure	Number Per Year (If Available) One	Two	Three	Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark	Comparison to Benchmark	Quartile Ranking Q1	Q2	Q3	Q4	Quartile Score	Severity Score	Source
Focus Area: Reduce Illness, Disability, and Death Related to Tobacco Use and Secondhand Smoke Exposure																
Prevention Agenda Indicators																
1. Percentage of Adults Ages 18 Plus Who Smoke, 2016				16.8%	N/A	16.2%	14.2%	**12.3%**	Worse		X					Prevention Agenda Dashboard
Quartile Summary for Prevention Agenda Indicators										0	1	0	0	100.0%	0.0%	
Other Indicators																
1. Rate of Chronic Lower Respiratory Disease Deaths per 100,000 Population, '14-16	26	34	23	72.0	72.8	**45.4**	34.8	N/A	Worse			X				Community Health Indicator Reports
2. Rate of Chronic Lower Respiratory Disease Hospitalizations per 10,000, Population, 2016				22.6	31.2	**28.0**	30.6	N/A	Meets/Better							Community Health Indicator Reports
3. Rate of Asthma Deaths per 100,000 Population, '14-16	1	2	1	3.5*	1.1*	**1.1**	1.5	N/A	Less than 10							Community Health Indicator Reports
4. Rate of Asthma Hospitalizations per 10,000 Population, 2016				N/A	N/A	**6.3**	10.8	N/A	Less than 10							Community Health Indicator Reports
5. Rate of Asthma Hospitalizations, Ages 25 - 44, per 10,000 Population, 2016				0.0*	N/A	**4.5**	5.6	N/A	Less than 10							Community Health Indicator Reports
6. Rate of Asthma Hospitalizations, Ages 45 - 64, per 10,000 Population, 2016				N/A	N/A	**5.1**	9.2	N/A	Less than 10							Community Health Indicator Reports
7. Rate of Asthma Hospitalizations, Ages 65 Plus, per 10,000 Population, 2016				N/A	N/A	**4.4**	8.9	N/A	Less than 10							Community Health Indicator Reports
8. Percentage of Adults with Asthma, '13-14				12.4%	12.0%	**10.1%**	9.5%	N/A	Worse	X						NYS Expanded Behavioral Risk Factor Surveillance System
9. Rate of Lung and Bronchus Cancer Deaths per 100,000 Population, '13-15	28	21	33	70.8	67.4	**53.0**	43.5	N/A	Worse		X					Community Health Indicator Reports
10. Rate of Lung and Bronchus Cancer Cases per 100,000 Population, '13-15	33	38	61	114.0	112.2	**84.3**	69.7	N/A	Worse		X					Community Health Indicator Reports
11. Number of Registered Tobacco Vendors per 100,000 Population, '15-16				158.0	555.8	**101.3**	107.8	N/A	Worse			X				NYS Department of Health Tobacco Enforcement Compliance Results
12. Percentage of Vendors with Sales to Minors Violations, '15-16				3.30	5.30	**3.90**	4.70	N/A	Meets/Better							NYS Department of Health Tobacco Enforcement Compliance Results
13. Percentage of Vendors with Complaints, '15-16				0.00	0.00	**0.04**	0.90	N/A	Meets/Better							NYS Department of Health Tobacco Enforcement Compliance Results
Quartile Summary for Other Indicators										1	2	2	0	38.5%	40.0%	
Quartile Summary for Focus Area Reduce Illness, Disability, and Death Related to Tobacco Use & Secondhand Smoke Exposure										1	3	2	0	42.9%	33.3%	

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Chronic Disease	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score	Source
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4			
Focus Area: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings																
Prevention Agenda Indicators																
1. Percentage of Adults Ages 50 - 75 Who Received Colorectal Screenings Based on Recent Guidelines, 2016				66.9%	N/A	69.7%	68.5%	**80.0%**	Worse	X						Prevention Agenda Dashboard
2. Rate of Asthma ED Visits per 10,000 Population, 2016				32.5	40.3	42.0	77.0	**75.1**	Meets/Better							Prevention Agenda Dashboard
3. Rate of Asthma ED Visits per 10,000 Population, Ages 0 - 4, 2016				60.4*	65.5	105.8	186.4	**196.5**	Less than 10							Prevention Agenda Dashboard
4. Rate of Short-term Diabetes Hospitalizations for Ages 6 - 17 per 10,000 Population, 2016				N/A	5.0	3.4	3.2	**3.06**	Less than 10							Prevention Agenda Dashboard
5. Rate of Short-term Diabetes Hospitalizations for Ages 18 Plus per 10,000 Population, 2016				N/A	5.0	4.1	4.0	**4.86**	Less than 10							Prevention Agenda Dashboard
6. Age-Adjusted Rate of Heart Attack Hospitalizations per 10,000 Population, 2016				11.9	24.9	14.8	13.9	**14.0**	Meets/Better							Prevention Agenda Dashboard
Quartile Summary for Prevention Agenda Indicators										1	0	0	0	16.7%	0.0%	
Other Indicators																
1. Rate of Asthma ED Visits for Ages 18 - 64 per 10,000 Population Ages 18 - 64, '12-14	136	74	104	43.6	52.4	**47.4**	77.3	N/A	Meets/Better							Asthma Summary Report
2. Rate of Asthma ED Visits for Ages 65 Plus per 10,000 Population Ages 65 Plus, '12-14	33	20	11	26.9	0.0	**19.1**	35.0	N/A	Worse		X					Asthma Dashboard-County Level
3. Rate of All Cancer Cases per 100,000 Population, '13-15	257	274	287	706.5	683.8	**629.8**	564.4	N/A	Worse	X						Community Health Indicator Reports
4. Rate of all Cancer Deaths per 100,000 Population, '13-15	98	81	108	245.3	227.3	**198.7**	176.2	N/A	Worse	X						Community Health Indicator Reports
5. Rate of Female Breast Cancer Cases per 100,000 Female Population, '13-15	35	32	45	201.5	173.3	**175.9**	158.6	N/A	Worse	X						Community Health Indicator Reports
6. Rate of Female Late Stage Breast Cancer Cases per 100,000 Female Population, '13-15	N/A	N/A	N/A	57.6	N/A	**53.1**	50.6	N/A	Worse	X						Community Health Indicator Reports
7. Rate of Female Breast Cancer Deaths per 100,000 Female Population, '13-15	N/A	N/A	N/A	28.8	N/A	**26.1**	24.6	N/A	Worse	X						Community Health Indicator Reports
8. Percentage of Women Aged 50-74 years Receiving Breast Cancer Screening Based on Recent Guidelines '13-14				78.4%	81.4%	**79.2%**	79.7%	N/A	Worse	X						NYS Expanded Behavioral Risk Factor Surveillance System
9. Rate of Cervix and Uterine Cancer Cases per 100,000 Female Population, '13-15	N/A	N/A	N/A	10.8*	N/A	**7.6**	8.5	N/A	Less than 10							Community Health Indicator Reports
10. Rate of Cervix and Uterine Cancer Deaths per 100,000 Female Population, '13-15	0	0	0	0.0*	N/A	**2.3**	2.7	N/A	Less than 10							Community Health Indicator Reports
11. Percentage of Women Aged 21-65 Years Receiving Cervical Cancer Screening Based on Recent Guidelines, 13/14				93.1%	86.0%	**83.5%**	82.2%	N/A	Meets/Better							NYS Expanded Behavioral Risk Factor Surveillance System
12. Rate of Ovarian Cancer Cases per 100,000 Female Population, '13 15	N/A	N/A	N/A	14.4*	N/A	**16.0**	14.8	N/A	Less than 10							Community Health Indicator Reports
13. Rate of Ovarian Cancer Deaths per 100,000 Female Population, '13-15	N/A	N/A	N/A	N/A	N/A	**10.4**	9.1	N/A	Less than 10							Community Health Indicator Reports
14. Rate of Colon and Rectal Cancer Cases per 100,000 Population, '13-15	20	22	25	57.9	55.0	**48.5**	45.7	N/A	Worse	X						Community Health Indicator Reports
15. Rate of Colon and Rectal Cancer Deaths per 100,000 Population, '13-15	6	8	10	20.7	18.9	**16.7**	15.6	N/A	Worse	X						Community Health Indicator Reports
16. Percentage of Adults Aged 50-75 years receiving colorectal cancer screening based on recent guidelines				66.9%	73.6%	**68.5%**	69.7%	N/A	Worse	X						NYS Expanded Behavioral Risk Factor Surveillance System
17. Rate of Prostate Cancer Deaths per 100,000 Male Population, '13-15	N/A	N/A	N/A	16.6	N/A	**17.7**	17.3	N/A	Meets/Better							Community Health Indicator Reports
18. Rate of Prostate Cancer Cases per 100,000 Male Population, '13-15	N/A	N/A	N/A	116.3	140.4	**151.7**	141.2	N/A	Meets/Better							Community Health Indicator Reports
19. Rate of Prostate Cancer Late Stage Cancer Cases per 100,000 Male Population, '13-15	N/A	N/A	N/A	28.2	30.0	**26.8**	25.2	N/A	Worse	X						Community Health Indicator Reports
20. Rate of Melanoma Cancer Deaths per 100,000 Population, '13-15	N/A	N/A	N/A	N/A	N/A	**3.0**	2.3	N/A	Less than 10							Community Health Indicator Reports
21. Percentage of Medicaid Enrollees with at Least One Preventive Dental Visit within the Year, '15-17	2,150	2,387	2,448	24.9%	25.7%	**28.3%**	28.0%	N/A	Worse	X						Community Health Indicator Reports
22. Percentage of Age Adjusted Adults with a Dental Visit Within the Last 12 Months, '13-14				62.7%	64.0%	**70.0%**	68.5%	N/A	Worse	X						NYS Expanded Behavioral Risk Factor Surveillance System
23. Oral Cancer Deaths per 100,000 Population, Aged 45-74 years, '13-15	N/A	N/A	N/A	12.2*	N/A	**4.2**	4.5	N/A	Less than 10							Community Health Indicator Reports
24. Lip, Oral Cavity and Pharynx Cancer Cases per 100,000 Population, '13-15	9	7	7	19.9	18.9	**14.7**	12.9	N/A	Worse		X					Community Health Indicator Reports
Quartile Summary for Other Indicators										12	2	0	0	58.3%	0.0%	
Quartile Summary for Focus Area Increase Access to High Quality Chronic Disease Preventive Care & Management										13	2	0	0	50.0%	0.0%	

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Maternal and Infant Health	Number Per Year (If Available) One	Two	Three	Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark	Comparison to Benchmark	Quartile Ranking Q1	Q2	Q3	Q4	Quartile Score	Severity Score	Source
Focus Area: Maternal and Infant Health																
Prevention Agenda Indicators																
1. Percentage Preterm Births < 37 Weeks of Total Births Where Gestation Period is Known, 2016				7.9%	9.8%	10.5%	10.3%	**10.2%**	Meets/Better							Prevention Agenda Dashboard
2. Ratio of Preterm Births (< 37 wks.) Black/NH to White/NH, 2014-2016				N/A	N/A	1.65	1.64	**1.42**	Less than 10							Prevention Agenda Dashboard
3. Ratio of Preterm Births (< 37 wks.) Hisp/Latino to White/NH, 2014-2016				N/A	N/A	1.28	1.29	**1.12**	Less than 10							Prevention Agenda Dashboard
4. Ratio of Preterm Births (< 37 wks.) Medicaid to Non-Medicaid, 2014-2016				1.28	N/A	1.10	1.06	**1.00**	Worse		X					Prevention Agenda Dashboard
5. Rate of Maternal Mortality per 100,000 Births, 2014-2016				0.0*	N/A	18.9	20.4	**21.0**	Less than 10							Prevention Agenda Dashboard
6. Percentage of Live Birth Infants Exclusively Breastfed in Delivery Hospital, 2016				65.3%	63.0%	50.9%	46.3%	**48.1%**	Meets/Better							Prevention Agenda Dashboard
7. Ratio of Infants Exclusively Breastfed in Delivery Hospital Black, non-Hispanic to White, non-Hispanic, 2014-2016				N/A	N/A	0.55	0.59	**0.57**	Less than 10							Prevention Agenda Dashboard
8. Ratio of Infants Exclusively Breastfed in Delivery Hospital Hispanic/Latino to White, non-Hispanic, 2014-2016				N/A	N/A	0.57	0.57	**0.56**	Less than 10							Prevention Agenda Dashboard
9. Ratio of Infants Exclusively Breastfed in Delivery Hospital Medicaid to Non-Medicaid Births, 2014-2016				0.87	N/A	0.68	0.59	**0.66**	Meets/Better							Prevention Agenda Dashboard
Quartile Summary for Prevention Agenda Indicators										0	1	0	0	11.1%	0.0%	
Other Indicators																
1. Percentage Preterm Births < 32 weeks of Total Births Where Gestation Period is Known, '14-16	1	6	5	1.4%	3.9%	**1.5%**	1.5%	N/A	Meets/Better							Community Health Indicator Reports
2. Percentage Preterm Births 32 to < 37 Weeks of Total Births Where Gestation Period is Known, '14-16	16	16	18	5.7%	7.5%	**7.4%**	7.3%	N/A	Meets/Better							Community Health Indicator Reports
3. Percentage of Total Births with Weights Less Than 1,500 grams, '14-16	1	5	4	1.1%	1.2%	**1.3%**	1.4%	N/A	Meets/Better							Community Health Indicator Reports
4. Percentage of Singleton Births with Weights Less Than 1,500 grams, '14-16	1	3	3	0.8*%	0.9%	**1.0%**	1.0%	N/A	Less than 10							Community Health Indicator Reports
5. Percentage of Total Births with Weights Less Than 2,500 grams, '14-16	14	19	18	5.7%	6.7*%	**7.6%**	7.9%	N/A	Meets/Better							Community Health Indicator Reports
6. Percentage of Singleton Births with Weights Less Than 2,500 grams, '14-16	10	17	14	4.7%	5.1*%	**5.7%**	6.0%	N/A	Meets/Better							Community Health Indicator Reports
7. Percentage of Total Births for Black, Non-Hispanic, with Weights Less than 2,500 Grams, '14-16				N/A	N/A	**12.9%**	12.2%	N/A	Less than 10							State and County Indicators for Tracking Public Health Priority Areas
8. Percentage of Total Births for Hispanic/Latino, with Weights Less than 2,500 Grams, '14-16				N/A	N/A	**7.5%**	7.7%	N/A	Less than 10							State and County Indicators for Tracking Public Health Priority Areas
9. Infant Mortality Rate per 1,000 Live Births, '14-16	0	0	1	1.1*	5.7*	**5.0**	4.5	N/A	Less than 10							Community Health Indicator Reports
10. Rate of Deaths (28 Weeks Gestation to < Seven Days) per 1,000 Live Births and Perinatal Deaths, '14-16	1	0	0	3.1*	3.5*	**5.3**	5.1	N/A	Less than 10							Community Health Indicator Reports
11. Percentage Early Prenatal Care of Total Births Where Prenatal Care Status is Known, '14-16	220	239	180	71.4%	75.4%	**77.0%**	75.2%	N/A	Worse	X						Community Health Indicator Reports
12. Percentage Early Prenatal Care for Black, Non-Hispanic, '14-16				N/A	N/A	**68.5%**	64.5%	N/A	Less than 10							State and County Indicators for Tracking Public Health Priority Areas
13. Percentage Early Prenatal Care for Hispanic/Latino, '14-16				N/A	N/A	**71.1%**	76.7%	N/A	Less than 10							State and County Indicators for Tracking Public Health Priority Areas
14. Percentage APGAR Scores of Less Than Six at Five Minute Mark of Births Where APGAR Score is Known, '14-16	3	6	2	1.2%	1.1%	**0.9%**	0.7%	N/A	Worse		X					Community Health Indicator Reports
15. Rate of Newborn Drug Related Hospitalizations per 10,000 Births, '13-15				106.1	0.0	**0.0**	104.8	N/A	Worse	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			Community Health Indicator Reports
16. Percentage WIC Women Breastfeeding for at least 6 months, '14-16				23.6%	N/A	**30.7%**	40.3%	N/A	Worse	X						Community Health Indicator Reports
17. Percentage Infants Receiving Any Breast Milk in Delivery Hospital, '14-16	186	207	185	85.1%	79.5%	**82.9%**	87.3%	N/A	Meets/Better							Community Health Indicator Reports
Quartile Summary for Other Indicators										2	1	0	0	17.6%	0.0%	
Quartile Summary for Focus Area Maternal and Infant Health										2	2	0	0	13.8%	0.0%	

	Number Per Year (If Available) One	Two	Three	Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark	Comparison to Benchmark	Quartile Ranking Q1	Q2	Q3	Q4	Quartile Score	Severity Score	Source
Focus Area: Preconception and Reproductive Health																
Prevention Agenda Indicators																
1. Percent of Births within 24 months of Previous Pregnancy, 2016				23.4%	23.2%	22.5%	19.8%	**17.0%**	Worse		X					Prevention Agenda Dashboard
2. Rate of Pregnancies Ages 15 - 17 year per 1,000 Females Ages 15-17, 2016				14.7	11.1	9.9	13.3	**25.6**	Less than 10							Prevention Agenda Dashboard

3. Ratio of Pregnancy Rates for Ages 15 - 17 Black, non-Hispanic to White, non-Hispanic, 2014-2016				N/A	N/A	4.30	4.80	**4.40**	Less than 10							Prevention Agenda Dashboard
4. Ratio of Pregnancy Rates for Ages 15 - 17 Hispanic/Latino to White, non-Hispanic, 2014-2016				N/A	N/A	3.50	4.40	**4.10**	Less than 10							Prevention Agenda Dashboard
5. Percent of Unintended Pregnancies among Total Births, 2016				33.7%	32.9%	24.9%	22.6%	**23.8%**	Worse		X					Prevention Agenda Dashboard
6. Ratio of Unintended Pregnancies Black, non-Hispanic to White, non-Hispanic, 2016				N/A	N/A	2.08	2.12	**1.90**	Less than 10							Prevention Agenda Dashboard
7. Ratio of Unintended Births Hispanic/Latino to White, non-Hispanic, 2016				N/A	N/A	1.49	1.68	**1.43**	Less than 10							Prevention Agenda Dashboard
8. Ratio of Unintended Births Medicaid to Non-Medicaid, 2016				1.10	N/A	1.96	1.71	**1.54**	Meets/Better							Prevention Agenda Dashboard
9. Percentage of Women Ages 18- 64 with Health Insurance, 2016				95.2%	N/A	N/A	93.1%	**100.0%**	Worse	X						Prevention Agenda Dashboard
Quartile Summary for Prevention Agenda Indicators										1	2	0	0	33.3%	0.0%	
Other Indicators																
1. Rate of Total Births per 1,000 Females Ages 15-44, '14-16	298	336	265	52.1	53.2	**57.2**	58.5	N/A	Meets/Better							Community Health Indicator Reports
2. Percent Multiple Births of Total Births, '14-16	9	6	10	2.8%	3.5%	**4.0%**	3.7%	N/A	Meets/Better							Community Health Indicator Reports
3. Percent C-Sections to Total Births, '14-16	104	103	92	33.3%	34.1%	**34.2%**	33.5%	N/A	Meets/Better							Community Health Indicator Reports
4. Rate of Total Pregnancies per 1,000 Females Ages 15-44, '14-16	361	421	335	58.8	64.5	**72.8**	83.8	N/A	Meets/Better							Community Health Indicator Reports
5. Rate of Births Ages 10 - 14 per 1,000 Females Ages 10-14, '14-16	1	0	0	0.4*	0.2*	**0.2**	0.2	N/A	Less than 10							Community Health Indicator Reports
6. Rate of Pregnancies Ages 10 - 14 per 1,000 Females Ages 10-14, '14 16	1	1	0	0.7*	0.3*	**0.4**	0.6	N/A	Less than 10							Community Health Indicator Reports
7. Rate of Births Ages 15 - 17 per 1,000 Females Ages 15-17, '14-16	10	11	10	14.4	12.5	**11.0**	15.1	N/A	Worse		X					Community Health Indicator Reports
8. Rate of Births Ages 15 - 19 per 1,000 Females Ages 15-19, '14-16	26	18	18	20.5	19.3	**13.2**	14.6	N/A	Worse			X				Community Health Indicator Reports
9. Rate of Pregnancies Ages 15 - 19 per 1,000 Females Ages 15-19, '14 16	32	32	25	26.8	28.1	**22.3**	29.8	N/A	Worse	X						Community Health Indicator Reports
10. Rate of Births Ages 18 - 19 per 1,000 Females Ages 18-19, '14-16	19	12	10	38.8	36.3*	**22.9**	25.6	N/A	Worse			X				Community Health Indicator Reports
11. Rate of Pregnancies Ages 18 - 19 per 1,000 Females Ages 18-19, '14-16	22	21	15	49.6	50.4	**37.5**	50.1	N/A	Worse		X					Community Health Indicator Reports
12. Percent Total Births to Women Ages 35 Plus, '14-16	44	57	39	15.6%	11.7%	**20.2%**	22.1%	N/A	Meets/Better							Community Health Indicator Reports
13. Rate of Abortions Ages 15 - 19 per 1000 Live Births, Mothers Ages 15-19, '14-16				333.3	434.5	**652.3**	990.8	N/A	Meets/Better							Community Health Indicator Reports
14. Rate of Abortions All Ages per 1000 Live Births to All Mothers, '14-16	30	49	45	126.5	181.4	**231.6**	370.9	N/A	Meets/Better							Community Health Indicator Reports
15. Percentage of WIC Women Pre-pregnancy Underweight, '10-12	12	11	11	5.4%	4.9%	**4.1%**	4.7%	N/A	Worse		X					Community Health Indicator Reports
16. Percentage of WIC Women Pre-pregnancy Overweight but not Obese, '10 - 12	45	38	54	21.6%	22.3%	**26.3%**	26.6%	N/A	Meets/Better							Community Health Indicator Reports
17. Percentage of WIC Women Pre-pregnancy Obese, '10 - 12	66	63	55	29.1%	33.3%	**28.0%**	24.2%	N/A	Worse	X						Community Health Indicator Reports
18. Percentage of WIC Women with Gestational Weight Gain Greater than Ideal, '09 - 11	103	105	87	52.9%	52.4%	**47.1%**	41.7%	N/A	Worse	X						Community Health Indicator Reports
19. Percentage of WIC Women with Gestational Diabetes, '09 - 11	14	23	20	9.6%	7.2%	**5.7%**	5.5%	N/A	Worse			X				Community Health Indicator Reports
20. Percentage of WIC Women with Gestational Hypertension, '09 - 11	31	32	23	14.5%	12.9%	**9.1%**	7.1%	N/A	Worse			X				Community Health Indicator Reports
Quartile Summary for Other Indicators										3	3	4	0	50.0%	40.0%	
Quartile Summary for Focus Area Preconception and Reproductive Health										9	4	3	0	55.2%	18.8%	

	Number Per Year (If Available)			Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score	
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4			
Focus Area: Child Health																
Prevention Agenda Indicators																
1. Percentage of Children Ages 0 - 15 Months with Government Insurance with Recommended Well Visits, 2016				88.5%	89.8%	82.8%	80.1%	**91.3%**	Worse	X						Prevention Agenda Dashboard
2. Percentage of Children Ages 3 - 6 Years with Government Insurance with Recommended Well Visits, 2016				82.6%	84.9%	82.3%	84.3%	**91.3%**	Worse	X						Prevention Agenda Dashboard
3. Percentage of Children Ages 12 -21 Years with Government Insurance with Recommended Well Visits, 2016				64.0%	69.5%	66.5%	68.1%	**67.1%**	Worse	X						Prevention Agenda Dashboard
4. Percentage of Children Ages 0 -19 with Health Insurance, 2016				96.9%	N/A	N/A	97.4%	**100.0%**	Worse	X						Prevention Agenda Dashboard
Quartile Summary for Prevention Agenda Indicators										4	0	0	0	100.0%	0.0%	
Other Indicators																
1. Rate of Children Deaths Ages 1 - 4 per 100,000 Population Children, '14-16	0	0	0	0.0*	26.8	**19.4**	18.2	N/A	Less than 10							Community Health Indicator Reports
2. Rate of Children Deaths Ages 5 - 9 per 100,000 Population Children, '14-16	0	0	0	0.0*	9.0	**9.7**	10.0	N/A	Less than 10							Community Health Indicator Reports
3. Rate of Children Deaths Ages 10 - 14 per 100,000 Population Children, '14-16	0	0	0	0.0*	15.5	**11.5**	11.4	N/A	Less than 10							Community Health Indicator Reports
4. Rate of Children Deaths Ages 5 - 14 per 100,000 Population Children, '14-16	0	0	0	0.0*	12.3	**10.6**	10.7	N/A	Less than 10							Community Health Indicator Reports
5. Rate of Adolescent Deaths Ages 15 - 19 per 100,000 Population Children, '14-16	0	0	1	15.3*	36.7	**32.6**	31.1	N/A	Less than 10							Community Health Indicator Reports
6. Rate of Asthma Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2016				N/A	N/A	**27.4**	43.5	N/A	Less than 10							Community Health Indicator Reports

7. Rate of Asthma Hospitalizations Children Ages 5 - 14 per 10,000 Population Children, 2016				0.0*	N/A	**9.5**	18.7	N/A	Less than 10							Community Health Indicator Reports
8. Rate of Asthma Hospitalizations Children Ages 0 - 17 per 10,000 Population Children, 2016				N/A	N/A	**12.9**	23.5	N/A	Less than 10							Community Health Indicator Reports
9. Rate of Gastroenteritis Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2016				0.0*	N/A	**8.1**	10.6	N/A	Less than 10							Community Health Indicator Reports
10. Rate of Otitis Media Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2016				0.0*	N/A	**24.4**	2.2	N/A	Less than 10							Community Health Indicator Reports
11. Rate of Pneumonia Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2016				N/A	N/A	**24.4**	30.9	N/A	Less than 10							Community Health Indicator Reports
12. Rate of ED Asthma Visits Children Ages 0 - 4 per 10,000 Population Children, 2016				60.4*	65.5	**105.8**	186.4	196.5	Less than 10							Asthma Dashboard-County Level
13. Percentage of Children born in 2013 Screened for Lead by Age 0-8 months, 2013				1.0*%	0.7%	**1.2%**	1.9%	N/A	Less than 10							Community Health Indicator Reports
14. Percentage of Children Born in 2013 Screened for Lead by Age 9-17 months, 2013				73.3%	77.5%	**71.7%**	74.8%	N/A	Meets/Better							Community Health Indicator Reports
15. Percentage of Children Born 2013 Screened for Lead by Age 36 months (at least two screenings), 2013				56.0%	63.7%	**55.9%**	62.8%	N/A	Meets/Better							Community Health Indicator Reports
16. Rate of Children Ages < 6 with Confirmed Blood Lead Levels >= 10 mg/dl Cases Per 1,000 Children Tested, '14-16	4	0	2	5.1*	11.4	**8.3**	4.3	N/A	Less than 10							Community Health Indicator Reports
17. Rate of Unintentional Injury Hospitalizations for Children Under Age 10 per 10,000 Population Children, 2016				N/A	N/A	**18.1**	18.9	N/A	Less than 10							Community Health Indicator Reports
18. Rate of Unintentional Injury Hospitalizations for Children Ages 10 - 14 per 10,000 Population Children, 2016				N/A	N/A	**12.5**	13.6	N/A	Less than 10							Community Health Indicator Reports
19. Rate of Unintentional Injury Hospitalizations for Children/Young Adults Ages 15 - 24 per 10,000 Population, 2016				14.4*	N/A	**23.1**	23.1	N/A	Less than 10							Community Health Indicator Reports
20. Rate of Asthma ED Visits for Children Ages 0 - 17 per 10,000 Population Children, 2016				55.7	N/A	**68.1**	137.1	N/A	Meets/Better							Asthma Summary Report
21. Percentage of Medicaid Enrollees Ages 2 - 20 with at Least One Dental Visit within the last year, '15-17	1,306	1,375	1,406	47.9%	48.0%	**48.0%**	47.5%	N/A	Worse	X						Community Health Indicator Reports
22. Percentage of 3rd Graders with Dental Caries, '09 - 11				50.4%	N/A	N/A	N/A	N/A	Meets/Better							Community Health Indicator Reports
23. Percentage of 3rd Graders with Dental Sealants, '09 - 11				34.5%	N/A	N/A	N/A	N/A	Meets/Better							Community Health Indicator Reports
24. Percentage of 3rd Graders with Dental Insurance, '09 - 11				86.6%	N/A	N/A	N/A	N/A	Meets/Better							Community Health Indicator Reports
25. Percentage of 3rd Graders with at Least One Dental Visit, '09 - 11				76.8%	N/A	N/A	N/A	N/A	Meets/Better							Community Health Indicator Reports
26. Percentage of 3rd Graders Taking Fluoride Tablets Regularly, '09 - 11				85.4%	N/A	N/A	N/A	N/A	Meets/Better							Community Health Indicator Reports
27. Rate of Caries Outpatient Visits for Children Ages 3 - 5 per 10,000 Population, 2016				221.3	164.1	**119.7**	90.0	N/A	Worse				X			Community Health Indicator Reports
28. Percentage of WIC Children Ages 2 - 4 Viewing Two Hours TV or Less Per Day, '14-16				87.0%	85.7%	**85.0%**	85.3%	N/A	Worse	X						Community Health Indicator Reports
Quartile Summary for Other Indicators										2	0	0	1	10.3%	33.3%	
Quartile Summary for Focus Area Child Health										6	0	0	1	21.2%	14.3%	

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HIV, STD, Immunization, Infect.	Number Per Year (If Available) One	Two	Three	Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark	Comparison to Benchmark	Quartile Ranking Q1	Q2	Q3	Q4	Quartile Score	Severity Score	Source
Focus Area: Human Immunodeficiency Virus (HIV)																
Prevention Agenda Indicators																
1. Rate of Newly Diagnosed HIV Cases per 100,000 Population, 2014-2016				3.9*	N/A	**6.9**	16.0	16.1	Less than 10							Prevention Agenda Dashboard
2. Ratio of Newly Diagnosed HIV Cases Black, non-Hispanic versus White, non-Hispanic, 2014-2016				-3.3	N/A	**20.1**	35.2	46.8	Less than 10							Prevention Agenda Dashboard
Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%	
Other Indicators																
1. Rate of AIDS Cases per 100,000 Population, '14-16				2.3*	N/A	**3.3**	7.7	N/A	Less than 10							Community Health Indicator Reports
2. Rate of AIDS Deaths per 100,000 Adjusted Population, '14-16	0	0	0	0.0*	N/A	**1.1**	3.0	N/A	Less than 10							Community Health Indicator Reports
Quartile Summary for Other Indicators										0	0	0	0	0.0%	0.0%	
Quartile Summary for Focus Area Human Immunodeficiency Virus (HIV)										0	0	0	0	0.0%	0.0%	

	Number Per Year (If Available) One	Two	Three	Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark	Comparison to Benchmark	Quartile Ranking Q1	Q2	Q3	Q4	Quartile Score	Severity Score	
Focus Area: Sexually Transmitted Disease (STDs)																
Prevention Agenda Indicators																
1. Rate of Primary and Secondary Syphilis for Males per 100,000 Male Population, 2016				0.0*	3.3	9.1	24.3	**10.1**	Less than 10							Prevention Agenda Dashboard
2. Rate of Primary and Secondary Syphilis for Females per 100,000 Female Population, 2016				0.0*	0.6	0.5	1.3	**0.4**	Less than 10							Prevention Agenda Dashboard
3. Rate of Gonorrhea Cases for Females Ages 15-44 per 100,000 Female Population Ages 15-44, 2016				17.7*	60.6	197.1	206.2	**183.4**	Less than 10							Prevention Agenda Dashboard
4. Rate of Gonorrhea Cases for Males Ages 15 - 44 per 100,000 Male Population Ages 15-44, 2016				13.6*	48.2	230.0	452.5	**199.5**	Less than 10							Prevention Agenda Dashboard
5. Rate of Chlamydia for Females Ages 15 - 44 per 100,000 Female Population Ages 15 - 44, 2016				689.5	1170.1	1351.6	1620.7	**1458.0**	Meets/Better							Prevention Agenda Dashboard
Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%	
Other Indicators																
1. Rate of Early Syphilis Cases per 100,000 Population, '14-16	0	0	0	0.0*	2.52*	**7.9**	25.1	N/A	Less than 10							Community Health Indicator Reports
2. Rate of Gonorrhea Cases per 100,000 Population, '14-16	17	27	18	8.6	0.0	**0.0**	111.8	N/A	Worse	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			Community Health Indicator Reports
3. Rate of Gonorrhea Ages 15 - 19 Cases per 100,000 Population Ages 15-19, '14-16	2	1	0	45.9*	45.8*	**209.9**	305.8	N/A	Less than 10							Community Health Indicator Reports
4. Rate of Chlamydia Cases All Males per 100,000 Male Population, '14-16	16	13	10	173.8	352.5	**569.5**	857.7	N/A	Meets/Better							Community Health Indicator Reports
5. Rate of Chlamydia Cases Males Ages 15 - 19 Cases per 100,000 Male Population Ages 15-19, '14-16	0	1	1	56.9*	403.1	**607.9**	922.5	N/A	Less than 10							Community Health Indicator Reports
6. Rate of Chlamydia Cases Males Ages 20 - 24 per 100,000 Male Population Ages 20-24, '14-16	7	7	4	480.3	779.1	**1,199.7**	1,638.0	N/A	Meets/Better							Community Health Indicator Reports
7. Rate of Chlamydia Cases All Females per 100,000 Female Population, '14-16	40	29	39	626.3	1,188.4	**1,300.3**	1,577.4	N/A	Meets/Better							Community Health Indicator Reports
8. Rate of Chlamydia Cases Females Ages 15- 19 per 100,000 Female Population Ages 15 - 19, '14-16	9	11	13	1,093.1	2,131.7	**2,300.5**	3,147.6	N/A	Meets/Better							Community Health Indicator Reports
9. Rate of Chlamydia Cases Females Ages 20 - 24 per 100,000 Female Population Ages 20-24, '14-16	16	11	16	1,611.0	2,717.9	**2,833.9**	3,424.6	N/A	Meets/Better							Community Health Indicator Reports
10. Rate of PID Hospitalizations Females Ages 15 - 44 per 10,000 Female Population Ages 15 - 44, 2016				0.0*	N/A	**1.9**	2.5	N/A	Less than 10							Community Health Indicator Reports
Quartile Summary for Other Indicators										0	0	0	0	0.0%	0.0%	
Quartile Summary for Sexually Transmitted Diseases										0	0	0	0	0.0%	0.0%	

	Number Per Year (If Available) One	Two	Three	Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark	Comparison to Benchmark	Quartile Ranking Q1	Q2	Q3	Q4	Quartile Score	Severity Score	
Focus Area: Vaccine Preventable Disease																
Prevention Agenda Indicators																
1. Percent of Children Ages 19 - 35 months with 4:3:1:3:3:1:4, 2016				73.0%	73.9%	64.0%	N/A	**80.0%**	Worse	X						Prevention Agenda Dashboard
2. Percent females 13 - 17 with 3 dose HPV vaccine, 2016				34.2%	42.6%	41.7%	N/A	**50.0%**	Meets/Better							Prevention Agenda Dashboard
3. Percent of Adults Ages 65 Plus With Flu Shots Within Last Year, 2016				57.8%	N/A	59.6%	59.5%	**70.0%**	Worse	X						Prevention Agenda Dashboard

Quartile Summary for Prevention Agenda Indicators										2	0	0	0	66.7%	0.0%	
Other Indicators																
1. Rate of Pertussis Cases per 100,000 Population, '13-15	7	2	0	7.8*	11.7	**5.9**	5.1	N/A	Less than 10							Community Health Indicator Reports
2. Rate of Pneumonia/Flu Hospitalizations Ages 65 Plus per 10,000 Population Age 65 Plus, '12-14				98.4	93.3	**93.7**	87.3	N/A	Worse	X						Community Health Indicator Reports
3. Percent of Adults Ages 65 Plus Ever Received a Pneumonia Shot, '13/14				73.7%	75.0%	**73.8%**	69.3%	N/A	Worse	X						NYS Expanded Behavioral Risk Factor Surveillance System
4. Rate of Mumps Cases per 100,000 Population, '13-15	0	0	1	0.4*	0.09	**0.70**	1.08	N/A	Less than 10							Community Health Indicator Reports
5. Rate of Meningococcal Cases per 100,000 Population, '13-15	0	0	0	0.0*	0.09*	**0.1***	0.1	N/A	Less than 10							Community Health Indicator Reports
6. Rate of H Influenza Cases per 100,000 Population, '13-15	0	3	0	2.6*	2.0	**1.7**	1.5	N/A	Less than 10							Community Health Indicator Reports
Quartile Summary for Other Indicators										2	0	0	0	33.3%	0.0%	
Quartile Summary for Focus Area Vaccine Preventable Diseases										4	0	0	0	44.4%	0.0%	

	Number Per Year (If Available)			**Average Rate, Ratio or Percentage for the Listed Years**	**Comparison Regions/Data**				**Comparison to Benchmark**	**Quartile Ranking**				**Quartile Score**	**Severity Score**	
	One	**Two**	**Three**		**ARHN**	**Upstate NY**	**New York State**	**2018 Prevention Agenda Benchmark**		**Q1**	**Q2**	**Q3**	**Q4**			
Focus Area: Healthcare Associated Infections																
Prevention Agenda Indicators																
1. Rate of Hospital Onset Clostridium difficile infections (CDIs) per 10,000 Patient Days, 2017				N/A	5.6	N/A	5.2	**5.94**	Less than 10							NYS Department of Health Hospital Report on Hospital Acquired Infections
2. Rate of Community Onset, Healthcare Facility Associated CDIs per 10,000 Patient Days, 2017				N/A	53.8	N/A	29.2	**2.05**	Less than 10							NYS Department of Health Hospital Report on Hospital Acquired Infections
Quartile Summary for Healthcare Associated Infections										0	0	0	0	0.0%	0.0%	

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Substance Abuse & Mental Health	Number Per Year (If Available) One	Two	Three	Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark	Comparison to Benchmark	Quartile Ranking Q1	Q2	Q3	Q4	Quartile Score	Severity Score	Source
Focus Area: Prevent Substance Abuse and Other Mental, Emtional, and Behavorial Disorders																
Prevention Agenda Indicators																
1. Age-adjusted Percent of Adults Binge Drinking within the Last Month, 2016				24.7%	N/A	19.1%	18.3%	**18.4%**	Worse		X					Prevention Agenda Dashboard
2. Age-adjusted Percent of Adults with Poor Mental Health (14 or More Days) in the Last Month, 2016				14.4%	N/A	11.2%	10.7%	**10.1%**	Worse		X					Prevention Agenda Dashboard
3. Age Adjusted Rate of Suicides per 100,000 Adjusted Population, '14-16				12.9	N/A	9.6	8.0	**5.9**	Worse				X			Prevention Agenda Dashboard
Quartile Summary for Prevention Agenda Indicators										0	2	0	1	100.0%	33.3%	
Other Indicators																
1 Rate of Suicides for Ages 15 - 19 per 100,000 Population Ages 15 - 19, '14-16				0.0*	10.7	**6.1**	5.0	N/A	Less than 10							Community Health Indicator Reports
2. Rate of Self-inflicted Hospitalizations 10,000 Population, 2016				2.4*	N/A	**4.1**	3.5	N/A	Less than 10							Community Health Indicator Reports
3. Rate of Self-inflicted Hospitalizations for Ages 15 - 19 per 10,000 Population Ages 15 - 19, 2016				N/A	N/A	**8.7**	7.6	N/A	Less than 10							Community Health Indicator Reports
4. Rate of Cirrhosis Deaths per 100,000 Population, '14-16				8.7	13.8	**7.4**	8.0	N/A	Worse	X						Community Health Indicator Reports
5. Rate of Cirrhosis Hospitalizations per 10,000 Population, 2016				2.6	1.5	**3.3**	3.0	N/A	Meets/Better							Community Health Indicator Reports
7. Rate of Alcohol-Related Crashes per 100,000, 2017				94.8	69.1	**53.20**	38.0	N/A	Worse				X			NYS Traffic Safety Statistical Repository
8. Rate of Alcohol-Related Injuries and Deaths per 100,000 Population, 2017				31.6	28.8	**10.5**	19.4	N/A	Worse				X			NYS Traffic Safety Statistical Repository
9. Rate of Drug-Related Hospitalizations per 10,000 Population, '12-14	42	43	18	8.8	14.6	**20.3**	24.0	N/A	Meets/Better							Community Health Indicator Reports
10. Rate of People Served in Mental Health Outpatient Settings Ages 17 and under per 100,000 Population Ages 17 and under, 2015				1,437.3	1,279.4	**642.2**	682.2	N/A	Worse				X			NYS Office of Mental Health, PCS Summary Report
11. Rate of People Served in Mental Health Outpatient Settings Ages 18 - 64 per 100,000 Population Ages 18 - 64, 2015				776.6	819.5	**620.5**	689.7	N/A	Worse		X					NYS Office of Mental Health, PCS Summary Report
12. Rate of People Served in Mental Health Outpatient Settings Ages 65+ per 100,000 Population Ages 65+, 2015				62.5	141.7	**170.3**	311.4	N/A	Meets/Better							NYS Office of Mental Health, PCS Summary Report
13. Rate of People Served in Emergency Settings for Mental Health Ages17 and under per 100,000 Population Ages under 17 and under, 2015				N/A	15.6	**20.0**	18.9	N/A	Less than 10							NYS Office of Mental Health, PCS Summary Report
14. Rate of People Served in Emergency Settings for Mental Health Ages 18 - 64 per 100,000 Population Ages 18 - 64, 2015				N/A	21.7	**20.0**	25.7	N/A	Less than 10							NYS Office of Mental Health, PCS Summary Report
15. Rate of People Served in Emergency Settings for Mental Health Ages 65+ per 100,000 Population Ages 65+, 2015				N/A	N/A	**5.7**	7.6	N/A	Less than 10							NYS Office of Mental Health, PCS Summary Report
Quartile Summary for Other Indicators										1	1	0	3	33.3%	60.0%	
Quartile Summary for Focus Area: Prevent Substance Abuse and Other Mental, Emotional, and Behavorial Disorders										1	3	0	4	44.4%	50.0%	

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Other	Number Per Year (If Available) One	Two	Three	Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark	Comparison to Benchmark	Quartile Ranking Q1	Q2	Q3	Q4	Quartile Score	Severity Score	Source
Other Non-Prevention Agenda Indicators																
1. Rate of Hepatitis A Cases per 100,000 Population, '14-16	0	0	1	0.9*	0.3*	**0.4**	0.5	N/A	Less than 10							Community Health Indicator Reports
2. Rate of Acute Hepatitis B Cases per 100,000 Population, '14-16	0	0	0	0.0*	0.0*	**0.3**	0.5	N/A	Less than 10							Community Health Indicator Reports
3. Rate of TB Cases per 100,000 Population, '14-16	1	0	0	0.9*	0.5*	**1.8**	3.9	N/A	Less than 10							Community Health Indicator Reports
4. Rate of e. Coli Shiga Toxin Cases per 100,000 Population,'14-16	1	1	0	1.7*	2.0	**2.0**	1.6	N/A	Less than 10							Community Health Indicator Reports
5. Rate of Salmonella Cases per 100,000 Population, '14-16	9	3	4	13.9	12.0	**12.0**	11.6	N/A	Worse	X						Community Health Indicator Reports
6. Rate of Shigella Cases per 100,000 Population, '14-16	0	0	0	0.0*	0.4	**2.5**	3.9	N/A	Less than 10							Community Health Indicator Reports
7. Rate of Lyme Disease Cases per 100,000 Population,'14-16	32	45	75	131.9	63.9	**N/A**	38.0	N/A	Meets/Better							Community Health Indicator Reports
8. Rate of Confirmed Rabies Cases per 100,000 Population, 2015				3.7	7.3	**3.3**	1.8	N/A	Worse	X						Department of Health, Wadsworth Center
Quartile Summary for Non-Prevention Agenda Issues										2	0	0	0	25.0%	0.0%	

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REPORTS

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score	Source
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4			
Focus Area: Disparities																
Prevention Agenda Indicators																
1. Percentage of Overall Premature Deaths (before age 65 years), 2016				19.1%	22.8%	22.4%	24.0%	**21.8%**	Meets/Better							Prevention Agenda Dashboard
2. Ratio of Black, Non-Hispanic Premature Deaths (Prior to Age 65) to White, Non-Hispanic Premature Deaths, '14 - 16				0.0*	1.69	2.05	1.95	**1.87**	Less than 10							Prevention Agenda Dashboard
3. Ratio of Hispanic/Latino Premature Deaths (Prior to Age 65) to White, Non-Hispanic Premature Deaths, '14 - 16				0.94+	2.12	2.16	1.87	**1.86**	Less than 10							Prevention Agenda Dashboard
4. Rate of Adult Age-Adjusted Preventable Hospitalizations per 10,000 Population (Ages 18 Plus), 2016				109.0	N/A	116.80	124.00	**122.0**	Meets/Better							Prevention Agenda Dashboard
5. Ratio of Black, Non-Hispanic Adult Preventable Age-Adjusted Hospitalizations to White, Non-Hispanic, 2016				0.0+	N/A	2.04	2.07	**1.85**	Less than 10							Prevention Agenda Dashboard
6. Ratio of Hispanic/Latino Adult Age-Adjusted Preventable Hospitalizations to White, Non-Hispanic, 2016				0.0+	N/A	1.27	1.28	**1.38**	Less than 10							Prevention Agenda Dashboard
7. Percentage of Adults (Ages 18 - 64) with Health Insurance, 2016				94.0%	N/A	N/A	91.4%	**100.0%**	Worse	X						Prevention Agenda Dashboard
8. Age-Adjusted Percentage of Adults with Regular Health Care Provider - Over 18 Years, 2016				88.5%	N/A	84.4%	82.6%	**90.8%**	Worse	X						Prevention Agenda Dashboard
Quartile Summary for Prevention Agenda Indicators										2	0	0	0	25.0%	0.0%	
Other Disparity Indicators																
1. Rate of Total Deaths per 100,000 Population, 2014-2016	362	452	414	1,065.4	990.5	**877.4**	769.8	N/A	Worse	X						Community Health Indicator Reports
2. Rate of Emergency Department Visits per 10,000 Population, 2016				4,912.1	4,866.3	**3,865.6**	4,169.1	N/A	Worse		X					Community Health Indicator Reports
3. Rate of Total Hospitalizations per 10,000 Population, 2016				708.4	1,039.9	**1,125.3**	1,154.4	N/A	Worse	X						Community Health Indicator Reports
4. Percentage of Adults (18 and Older) Who Did Not Receive Medical Care Due to Costs, 2016				6.7%	9.9%	**9.8%**	11.2%	N/A	Meets/Better							NYS Expanded Behavioral Risk Factor Surveillance System
5. Percentage of Adults (18 and Older) Who Report 14 Days or More of Poor Physical Health, 2016				15.4%	14.3%	**12.0%**	11.3%	N/A	Worse		X					NYS Expanded Behavioral Risk Factor Surveillance System
6. Percentage of Adults (18 and Older) Living with a Disability, 2016				26.8%	25.6%	**22.8%**	22.9%	N/A	Worse	X						NYS Expanded Behavioral Risk Factor Surveillance System
Quartile Summary for Other Indicators										3	2	0	0	83.3%	0.0%	
Quartile Summary for Focus Area Disparities										5	2	0	0	50.0%	0.0%	

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score	Source
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4			
Focus Area: Injuries, Violence, and Occupational Health																
Prevention Agenda Indicators																
1. Rate of Hospitalizations due to Falls per 10,000 - Ages 65+, 2016				110.3	155.7	189.9	179.0	**204.6**	Meets/Better							Prevention Agenda Dashboard
2. Rate of ED Visits due to Falls for Children Ages 1 - 4 per 10,000 Population Children, 2016				569.3	523.8	408.5	397.3	**429.1**	Worse		X					Prevention Agenda Dashboard
3. Rate of Assault-Related Hospitalizations per 10,000 Population, 2016				0.0*	1.3	2.2	3.2	**4.3**	Less than 10							Prevention Agenda Dashboard
4. Ratio of Black, Non-Hispanic Assault-Related Hospitalizations to White, Non-Hispanic Assault Related Hospitalizations, 2016				N/A	N/A	6.4	6.2	**6.7**	Less than 10							Prevention Agenda Dashboard
5. Ratio of Hispanic/Latino Assault-Related Hospitalizations to White, Non-Hispanic Assault Related Hospitalizations, 2016				N/A	N/A	2.1	2.8	**2.8**	Less than 10							Prevention Agenda Dashboard
6. Ratio of Assault-Related Hospitalizations for Low-Income versus Non-Low Income Zip Codes, 2016				N/A	N/A	2.9	3.0	**2.9**	Less than 10							Prevention Agenda Dashboard
7. Rate of ED Occupational Injuries Among Working Adolescents Ages 15 - 19 per 10,000 Population, 2016				82.1	64.9	29.4	21.3	**33.0**	Worse				X			Prevention Agenda Dashboard
Quartile Summary for Prevention Agenda Indicators										0	1	0	1	28.6%	50.0%	
Other Indicators																
1. Falls hospitalization rate per 10,000 - Aged <10 years, 2016				0.0*	N/A	**6.5**	7.4	N/A	Less than 10							Community Health Indicator Reports
2. Falls hospitalization rate per 10,000 - Aged 10-14 years, 2016				0.0*	N/A	**3.6**	4.5	N/A	Less than 10							Community Health Indicator Reports
3. Falls hospitalization rate per 10,000 - Aged 15-24 years, 2016				N/A	N/A	**4.2**	4.8	N/A	Less than 10							Community Health Indicator Reports
4. Falls hospitalization rate per 10,000 - Aged 25-64 years, 2016				11.6	N/A	**17.4**	17.0	N/A	Meets/Better							Community Health Indicator Reports
5. Rate of Violent Crimes per 100,000 Population, 2017				172.6	171.8	**214.9**	355.6	N/A	Meets/Better							Division of Criminal Justice Services Index, Property, and Firearm Rates
6. Rate of Property Crimes per 100,000 Population, 2017				975.6	1,255.3	**1,479.5**	1,466.1	N/A	Meets/Better							Division of Criminal Justice Services Index, Property, and Firearm Rates
7. Rate of Total Crimes per 100,000 Population, 2017				1,148.2	1,427.1	**1,694.4**	1,821.7	N/A	Meets/Better							Division of Criminal Justice Services Index, Property, and Firearm Rates
8. Incidence Rate of Malignant Mesothelioma Cases, Ages 15 Plus, per 100,000 Population, '13-15				N/A	N/A	**1.6**	**1.3**	N/A	Less than 10							Community Health Indicator Reports
9. Rate of Pneumoconiosis Hospitalizations, Ages 15 Plus, per 100,000 Population, 2016				N/A	N/A	**8.8**	6.3	N/A	Less than 10							Community Health Indicator Reports
10. Rate of Asbestosis Hospitalizations, Ages 15 Plus, per 10,000 Population, 2016				N/A	N/A	**7.7**	5.5	N/A	Less than 10							Community Health Indicator Reports
11. Rate of Work-Related Hospitalizations, Employed Ages 16 Plus per 100,000 Individuals Employed, '14-16	19	16	15	101.8	N/A	**167.3**	133.8	N/A	Meets/Better							Community Health Indicator Reports
12. Rate of Elevated Blood Lead Levels Ages 16 Plus Employed per 100,000 Individuals Employed, '14-16	3	1	4	16.3*	17.9	**18.5**	17.3	N/A	Less than 10							Community Health Indicator Reports
13. Rate of Total Motor Vehicle Crashes per 100,000, 2017				2,779.5	2,162.0	**2,022.7**	1,558.5	N/A	Worse		X					NYS Traffic Safety Statistical Repository
14. Rate of Speed-Related Accidents per 100,000 Population, 2017				685.0	364.7	**214.2**	141.6	N/A	Worse				X			NYS Traffic Safety Statistical Repository
15. Rate of Motor Vehicle Accident Deaths per 100,000 Population, 2017				7.9	7.3	**7.1**	5.0	N/A	Worse	X						NYS Traffic Safety Statistical Repository
16. Rate of Traumatic Brain Injury Hospitalizations per 10,000 Population, 2016	19	13	8	3.4	N/A	**8.6**	8.3	N/A	Meets/Better							Community Health Indicator Reports
17. Rate of Unintentional Injury Hospitalizations per 10,000 Population, 2016	236	202	191	54.0	61.8	**68.3**	63.3	N/A	Meets/Better							Community Health Indicator Reports
18. Rate of Unintentional Injury Hospitalizations Ages 10 to 14 per 10,000 Population, 2016				10.2	N/A	**12.5**	13.6	N/A	Less than 10							Community Health Indicator Reports
19. Rate of Unintentional Injury Hospitalizations Ages 65 Plus per 10,000 Population, 2016	161	133	121	174.1	198.0	**239.3**	227.9	N/A	Meets/Better							Community Health Indicator Reports
20. Rate of Poisoning Hospitalizations per 10,000 Population, 2016	35	33	14	7.0	N/A	**7.1**	7.2	N/A	Meets/Better							Community Health Indicator Reports
Quartile Summary for Other Indicators										1	1	0	1	15.0%	33.3%	
Quartile Summary for Focus Area Injuries, Violence, and Occupational Health										1	2	0	2	18.5%	40.0%	

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score	Source
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4			
Focus Area: Outdoor Air Quality																
1. Number of Days with Unhealthy Ozone, 2015-2017				N/A	N/A	21.0	N/A	**0.00**	Less than 10							Prevention Agenda Dashboard
2. Number of Days with Unhealthy Particulate Matter, 2015-2017				N/A	N/A	0.00	N/A	**0.00**	Less than 10							Prevention Agenda Dashboard
Quartile Summary for Focus Area Outdoor Air Quality										0	0	0	0	0.0%	0.0%	

Focus Area: Built Environment																
1. Percentage of the Population that Live in Jurisdictions that Adopted Climate Smart Communities Pledge, 2017				100.0%	17.2%	61.6%	35.6%	**32.0%**	Less than 10							Prevention Agenda Dashboard
2. Percentage of Commuters Who Use Alternative Modes of Transportation to Work, 2012-2016				19.7%	19.0%	22.9%	45.7%	**49.2%**	Worse			X				Prevention Agenda Dashboard
3. Percentage of Population with Low-Income and Low-Access to a Supermarket or Large Grocery Store, 2015				2.2%	6.0%	3.9%	2.3%	**2.2%**	Meets/Better							Prevention Agenda Dashboard
4. Percentage of Adults Experiencing Food Insecurity '13/14				20.9%	23.3%	**22.7%**	29.0%	N/A	Meets/Better							NYS Expanded Behavioral Risk Factor Surveillance System
5. Percentage of Adults Experiencing Housing Insecurity, 2016				29.4%	29.9%	**30.9%**	35.5%	N/A	Meets/Better							NYS Expanded Behavioral Risk Factor Surveillance System
6. Percentage of Homes in Healthy Neighborhoods Program that have Fewer Asthma Triggers During Home Revisits, 2013-2016				N/A	N/A	20.5%	N/A	**25.0%**	Meets/Better							Prevention Agenda Dashboard
Quartile Summary for Focus Area Built Environment										0	0	1	0	16.7%	100.0%	

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score	Source
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4			
Focus Area: Water Quality																
1. Percentage of Residents Served by Community Water Systems with Optimally Fluoridated Water, 2017				0.0%	26.9%	46.6%	70.8%	**78.5%**	Worse				X			Prevention Agenda Dashboard
Quartile Summary for Focus Area Water Quality										0	0	0	1	100.0%	100.0%	
Focus Area: Reduce Obesity in Children and Adults																
Prevention Agenda Indicators																
1. Percentage of Adults Ages 18 Plus Who are Obese, 2016				32.2%	N/A	**27.4%**	25.5%	23.2%	Worse		X					Prevention Agenda Dashboard
2. Percentage of Public School Children Who are Obese, '14 - 16				21.4%	N/A	17.3%	N/A	**16.7%**	Worse		X					Prevention Agenda Dashboard
Quartile Summary for Prevention Agenda Indicators										1	1	0	0	100.0%	0.0%	
Other Indicators																
1. Percentage of Total Students Overweight, '16-18				16.5%	17.5%	**16.5%**	N/A	N/A	Meets/Better							Student Weight Status Category Reporting System (SWSCRS) Data
2. Percentage of Elementary Students Overweight, Not Obese, '16-18				15.2%	17.0%	**15.7%**	N/A	N/A	Meets/Better							Student Weight Status Category Reporting System (SWSCRS) Data
3. Percentage of Elementary Student Obese, '16-18				18.7%	18.3%	**16.0%**	N/A	N/A	Worse	X						Student Weight Status Category Reporting System (SWSCRS) Data
4. Percentage of Middle and High School Students Overweight, Not Obese, '16-18				15.9%	18.1%	**17.4%**	N/A	N/A	Meets/Better							Student Weight Status Category Reporting System (SWSCRS) Data
5. Percentage of Middle and High School Students Obese, '16-18				26.8%	23.6%	**18.8%**	N/A	N/A	Worse		X					Student Weight Status Category Reporting System (SWSCRS) Data
6. Percentage of WIC Children Ages 2 - 4 Obese, '14-16				16.4%	15.9%	**15.2%**	13.9%	N/A	Worse	X						Community Health Indicator Reports
7. Percentage of Age Adjusted Adults (Ages 18 Plus) Overweight or Obese, 2016				68.2%	70.2%	**63.7%**	60.8%	N/A	Worse	X						NYS Expanded Behavioral Risk Factor Surveillance System
8. Percentage of Age Adjusted Adults (Ages 18 Plus) Who Participated in Leisure Activities Last 30 Days, 2016				76.6%	73.9%	**74.6%**	73.7%	N/A	Meets/Better							NYS Expanded Behavioral Risk Factor Surveillance System
9. Number of Recreational and Fitness Facilities per 100,000 Population, 2014				5.9	5.5	**18.7**	19.2	N/A	Worse			X				USDA Economic Research Service Fitness Facilities Data
10. Percentage of Age Adjusted Adults (Ages 18 Plus) with Cholesterol Check, '13/14				70.0%	79.7%	**84.8%**	84.2%	N/A	Worse	X						NYS Expanded Behavioral Risk Factor Surveillance System
11. Percentage of Adults (18 Plus) with Physician Diagnosed High Blood Pressure, '13/14				37.2%	36.0%	**33.0%**	31.7%	N/A	Worse	X						NYS Expanded Behavioral Risk Factor Surveillance System
12. Rate of Cardiovascular Disease Deaths per 100,000 Population, '14-16	124	135	103	314.1	295.6	**295.7**	272.2	N/A	Worse	X						Community Health Indicator Reports
13. Rate of Cardiovascular Premature Deaths (Ages 35 - 64) per 100,000 Population, '14-16	19	15	11	92.4	111.7	**101.0**	102.4	N/A	Meets/Better							Community Health Indicator Reports
14. Rate of Cardiovascular Pretransport Deaths per 100,000 Population, '14-16	83	71	58	183.9	165.4	**169.6**	153.2	N/A	Worse	X						Community Health Indicator Reports
15. Rate of Cardiovascular Hospitalizations per 10,000 Population, 2016				107.6	148.7	**1539.0**	149.9	N/A	Meets/Better							Community Health Indicator Reports
16. Rate of Diseases of the Heart Deaths per 100,000 Population, '14-16	105	103	82	251.6	233.2	**236.5**	220.7	N/A	Worse	X						Community Health Indicator Reports
17. Rate of Diseases of the Heart Premature Deaths (Ages 35 - 64) per 100,000 Population, '14-16	17	15	9	84.2	95.9	**82.8**	83.4	N/A	Worse	X						Community Health Indicator Reports
18. Rate of Disease of the Heart Pretransport Deaths per 100,000 Population, '14-16	73	57	44	151.0	134.0	**140.7**	131.0	N/A	Worse	X						Community Health Indicator Reports
19. Rate of Disease of the Heart Hospitalizations per 10,000 Population, 2016				76.1	103.1	**104.9**	100.3	N/A	Meets/Better							Community Health Indicator Reports
20. Rate of Coronary Heart Diseases Deaths per 100,000 Population, '14-16	80	63	55	171.8	154.9	**162.7**	168.7	N/A	Worse	X						Community Health Indicator Reports
21. Rate of Coronary Heart Diseases Premature Deaths (Ages 35 - 64) per 100,000 Population, '14-16	12	11	7	61.6	68.0	**60.5**	66.4	N/A	Worse	X						Community Health Indicator Reports
22. Rate of Coronary Heart Disease Pretransport Deaths per 100,000 Population, '14-16	55	34	34	106.7	91.1	**101.3**	105.0	N/A	Worse	X						Community Health Indicator Reports
23. Rate of Coronary Heart Disease Hospitalizations per 10,000 Population, 2016				28.1	38.6	**35.4**	35.0	N/A	Meets/Better							Community Health Indicator Reports
24. Rate of Congestive Heart Failure Deaths per 100,000, '14-16	5	14	5	20.8	17.6	**24.4**	16.5	N/A	Meets/Better							Community Health Indicator Reports
25. Rate of Congestive Heart Failure Premature Deaths (Ages 35 - 64) per 100,000 Population, '14-16	1	3	1	10.3*	4.8	**3.3**	2.5	N/A	Less than 10							Community Health Indicator Reports
26. Rate of Congestive Heart Failure Pretransport Deaths per 100,000 Population, '14-16	4	12	1	14.7	10.9	**14.5**	9.4	N/A	Worse	X						Community Health Indicator Reports
27. Rate of Congestive Heart Failure Hospitalizations per 10,000 Population, 2016				17.3	24.2	**25.6**	24.8	N/A	Meets/Better							Community Health Indicator Reports
28. Rate of Cerebrovascular (Stroke) Deaths per 100,000 Population, '14-16	12	21	14	40.8	40.2	**38.1**	31.3	N/A	Worse	X						Community Health Indicator Reports
29. Rate of Cerebrovascular (Stroke) Hospitalizations per 10,000 Population, 2016				15.7	23.8	**26.9**	25.4	N/A	Meets/Better							Community Health Indicator Reports
30. Rate of Hypertension Hospitalizations (Ages 18 Plus) per 10,000 Population, 2016				3.5	2.7	**9.4**	9.7	N/A	Meets/Better							Community Health Indicator Reports
31. Rate of Diabetes Deaths per 100,000 Population, '14-16	17	15	14	39.9	29.5	**19.8**	20.3	N/A	Worse				X			Community Health Indicator Reports
32. Rate of Diabetes Hospitalizations (Primary Diagnosis) per 10,000 Population, 2016				10.5	14.5	**15.4**	17.5	N/A	Meets/Better							Community Health Indicator Reports
33. Rate of Diabetes Hospitalizations (Any Diagnosis) per 10,000 Population, 2016				161.1	246.1	**237.2**	248.1	N/A	Meets/Better							Community Health Indicator Reports
Quartile Summary for Other Indicators										15	1	1	1	54.5%	11.1%	
Quartile Summary for Focus Area Reduce Obesity in Children and Adults										16	2	1	1	57.1%	10.0%	

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score	Source
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4			
Focus Area: Reduce Illness, Disability, and Death Related to Tobacco Use and Secondhand Smoke Exposure																
Prevention Agenda Indicators																
1. Percentage of Adults Ages 18 Plus Who Smoke, 2016				16.8%	N/A	16.2%	14.2%	**12.3%**	Worse		X					Prevention Agenda Dashboard
Quartile Summary for Prevention Agenda Indicators										0	1	0	0	100.0%	0.0%	
Other Indicators																
1. Rate of Chronic Lower Respiratory Disease Deaths per 100,000 Population, '14-16	26	34	23	72.0	72.8	**45.4**	34.8	N/A	Worse			X				Community Health Indicator Reports
2. Rate of Chronic Lower Respiratory Disease Hospitalizations per 10,000, Population, 2016				22.6	31.2	**28.0**	30.6	N/A	Meets/Better							Community Health Indicator Reports
3. Rate of Asthma Deaths per 100,000 Population, '14-16	1	2	1	3.5	1.1*	**1.1**	1.5	N/A	Worse				X			Community Health Indicator Reports
4. Rate of Asthma Hospitalizations per 10,000 Population, 2016				N/A	N/A	**6.3**	10.8	N/A	Less than 10							Community Health Indicator Reports
5. Rate of Asthma Hospitalizations, Ages 25 - 44, per 10,000 Population, 2016				0.0*	N/A	**4.5**	5.6	N/A	Less than 10							Community Health Indicator Reports
6. Rate of Asthma Hospitalizations, Ages 45 - 64, per 10,000 Population, 2016				N/A	N/A	**5.1**	9.2	N/A	Less than 10							Community Health Indicator Reports
7. Rate of Asthma Hospitalizations, Ages 65 Plus, per 10,000 Population, 2016				N/A	N/A	**4.4**	8.9	N/A	Less than 10							Community Health Indicator Reports
8. Percentage of Adults with Asthma, '13-14				12.4%	12.0%	**10.1%**	9.5%	N/A	Worse	X						NYS Expanded Behavioral Risk Factor Surveillance System
9. Rate of Lung and Bronchus Cancer Deaths per 100,000 Population, '13-15	28	21	33	70.8	67.4	**53.0**	43.5	N/A	Worse		X					Community Health Indicator Reports
10. Rate of Lung and Bronchus Cancer Cases per 100,000 Population, '13-15	33	38	61	114.0	112.2	**84.3**	69.7	N/A	Worse		X					Community Health Indicator Reports
11. Number of Registered Tobacco Vendors per 100,000 Population, '15-16				158.0	555.8	**101.3**	107.8	N/A	Worse			X				NYS Department of Health Tobacco Enforcement Compliance Results
12. Percentage of Vendors with Sales to Minors Violations, '15-16				3.30	5.30	**3.90**	4.70	N/A	Meets/Better							NYS Department of Health Tobacco Enforcement Compliance Results
13. Percentage of Vendors with Complaints, '15-16				0.00	0.00	**0.04**	0.90	N/A	Meets/Better							NYS Department of Health Tobacco Enforcement Compliance Results
Quartile Summary for Other Indicators										1	2	2	1	46.2%	50.0%	
Quartile Summary for Focus Area Reduce Illness, Disability, and Death Related to Tobacco Use & Secondhand Smoke Exposure										1	3	2	1	50.0%	42.9%	

	Number Per Year (If Available)			Rate, Ratio or Percentage for the Listed	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score	Source
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4			
Focus Area: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings																
Prevention Agenda Indicators																
1. Percentage of Adults Ages 50 - 75 Who Received Colorectal Screenings Based on Recent Guidelines, 2016				66.9%	N/A	69.7%	68.5%	**80.0%**	Worse	X						Prevention Agenda Dashboard
2. Rate of Asthma ED Visits per 10,000 Population, 2016				32.5	40.3	42.0	77.0	**75.1**	Meets/Better							Prevention Agenda Dashboard
3. Rate of Asthma ED Visits per 10,000 Population, Ages 0 - 4, 2016				60.4*	65.5	105.8	186.4	**196.5**	Less than 10							Prevention Agenda Dashboard
4. Rate of Short-term Diabetes Hospitalizations for Ages 6 - 17 per 10,000 Population, 2016				N/A	5.0	3.4	3.2	**3.06**	Less than 10							Prevention Agenda Dashboard
5. Rate of Short-term Diabetes Hospitalizations for Ages 18 Plus per 10,000 Population, 2016				N/A	5.0	4.1	4.0	**4.86**	Less than 10							Prevention Agenda Dashboard
6. Age-Adjusted Rate of Heart Attack Hospitalizations per 10,000 Population, 2016				11.9	24.9	14.8	13.9	**14.0**	Meets/Better							Prevention Agenda Dashboard
Quartile Summary for Prevention Agenda Indicators										1	0	0	0	16.7%	0.0%	
Other Indicators																
1. Rate of Asthma ED Visits for Ages 18 - 64 per 10,000 Population Ages 18 - 64, '12-14	136	74	104	43.6	52.4	**47.4**	77.3	N/A	Meets/Better							Asthma Summary Report
2. Rate of Asthma ED Visits for Ages 65 Plus per 10,000 Population Ages 65 Plus, '12-14	33	20	11	26.9	22.7	**19.1**	35.0	N/A	Worse		X					Asthma Dashboard-County Level
3. Rate of All Cancer Cases per 100,000 Population, '13-15	257	274	287	706.5	683.8	**629.8**	564.4	N/A	Worse	X						Community Health Indicator Reports
4. Rate of all Cancer Deaths per 100,000 Population, '13-15	98	81	108	245.3	227.3	**198.7**	176.2	N/A	Worse	X						Community Health Indicator Reports
5. Rate of Female Breast Cancer Cases per 100,000 Female Population, '13-15	35	32	45	201.5	173.3	**175.9**	158.6	N/A	Worse	X						Community Health Indicator Reports
6. Rate of Female Late Stage Breast Cancer Cases per 100,000 Female Population, '13-15	N/A	N/A	N/A	57.6	N/A	**53.1**	50.6	N/A	Worse	X						Community Health Indicator Reports
7. Rate of Female Breast Cancer Deaths per 100,000 Female Population, '13-15	N/A	N/A	N/A	28.8	N/A	**26.1**	24.6	N/A	Worse	X						Community Health Indicator Reports
8. Percentage of Women Aged 50-74 years Receiving Breast Cancer Screening Based on Recent Guidelines '13-14				78.4%	81.4%	**79.2%**	79.7%	N/A	Worse	X						NYS Expanded Behavioral Risk Factor Surveillance System
9. Rate of Cervix and Uterine Cancer Cases per 100,000 Female Population, '13-15	N/A	N/A	N/A	10.8*	N/A	**7.6**	8.5	N/A	Less than 10							Community Health Indicator Reports
10. Rate of Cervix and Uterine Cancer Deaths per 100,000 Female Population, '13-15	0	0	0	0.0*	N/A	**2.3**	2.7	N/A	Less than 10							Community Health Indicator Reports
11. Percentage of Women Aged 21-65 Years Receiving Cervical Cancer Screening Based on Recent Guidelines, 13/14				93.1%	86.0%	**83.5%**	82.2%	N/A	Meets/Better							NYS Expanded Behavioral Risk Factor Surveillance System
12. Rate of Ovarian Cancer Cases per 100,000 Female Population, '13-15	N/A	N/A	N/A	14.4*	N/A	**16.0**	14.8	N/A	Less than 10							Community Health Indicator Reports
13. Rate of Ovarian Cancer Deaths per 100,000 Female Population, '13-15	N/A	N/A	N/A	N/A	N/A	**10.4**	9.1	N/A	Less than 10							Community Health Indicator Reports
14. Rate of Colon and Rectal Cancer Cases per 100,000 Population, '13-15	20	22	25	57.9	55.0	**48.5**	45.7	N/A	Worse	X						Community Health Indicator Reports
15. Rate of Colon and Rectal Cancer Deaths per 100,000 Population, '13-15	6	8	10	20.7	18.9	**16.7**	15.6	N/A	Worse	X						Community Health Indicator Reports
16. Percentage of Adults Aged 50-75 years receiving colorectal cancer screening based on recent guidelines				66.9%	73.6%	**68.5%**	69.7%	N/A	Worse	X						NYS Expanded Behavioral Risk Factor Surveillance System
17. Rate of Prostate Cancer Deaths per 100,000 Male Population, '13-15	N/A	N/A	N/A	16.6	N/A	**17.7**	17.3	N/A	Meets/Better							Community Health Indicator Reports
18. Rate of Prostate Cancer Cases per 100,000 Male Population, '13-15	N/A	N/A	N/A	116.3	140.4	**151.7**	141.2	N/A	Meets/Better							Community Health Indicator Reports
19. Rate of Prostate Cancer Late Stage Cancer Cases per 100,000 Male Population, '13-15	N/A	N/A	N/A	28.2	30.0	**26.8**	25.2	N/A	Worse	X						Community Health Indicator Reports
20. Rate of Melanoma Cancer Deaths per 100,000 Population, '13-15	N/A	N/A	N/A	N/A	N/A	**3.0**	2.3	N/A	Less than 10							Community Health Indicator Reports
21. Percentage of Medicaid Enrollees with at Least One Preventive Dental Visit within the Year, '15-17	2,150	2,387	2,448	24.9%	25.7%	**28.3%**	28.0%	N/A	Worse	X						Community Health Indicator Reports
22. Percentage of Age Adjusted Adults with a Dental Visit Within the Last 12 Months, '13-14				62.7%	64.0%	**70.0%**	68.5%	N/A	Worse	X						NYS Expanded Behavioral Risk Factor Surveillance System
23. Oral Cancer Deaths per 100,000 Population, Aged 45-74 years, '13-15	N/A	N/A	N/A	12.2*	N/A	**4.2**	4.5	N/A	Less than 10							Community Health Indicator Reports
24. Lip, Oral Cavity and Pharynx Cancer Cases per 100,000 Population, '13-15	9	7	7	19.9	18.9	**14.7**	12.9	N/A	Worse		X					Community Health Indicator Reports
Quartile Summary for Other Indicators										12	2	0	0	58.3%	0.0%	
Quartile Summary for Focus Area Increase Access to High Quality Chronic Disease Preventive Care & Management										13	2	0	0	50.0%	0.0%	

	Number Per Year (If Available)			Rate, Ratio or Percentage for the Listed	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score	Source
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4			
Focus Area: Maternal and Infant Health																
Prevention Agenda Indicators																
1. Percentage Preterm Births < 37 Weeks of Total Births Where Gestation Period is Known, 2016				7.9%	9.8%	10.5%	10.3%	**10.2%**	Meets/Better							Prevention Agenda Dashboard
2. Ratio of Preterm Births (< 37 wks.) Black/NH to White/NH, 2014-2016				N/A	N/A	1.65	1.64	**1.42**	Less than 10							Prevention Agenda Dashboard
3. Ratio of Preterm Births (< 37 wks.) Hisp/Latino to White/NH, 2014-2016				N/A	N/A	1.28	1.29	**1.12**	Less than 10							Prevention Agenda Dashboard
4. Ratio of Preterm Births (< 37 wks.) Medicaid to Non-Medicaid, 2014-2016				1.28	N/A	1.10	1.06	**1.00**	Worse		X					Prevention Agenda Dashboard
5. Rate of Maternal Mortality per 100,000 Births, 2014-2016				0.0*	N/A	18.9	20.4	**21.0**	Less than 10							Prevention Agenda Dashboard
6. Percentage of Live Birth Infants Exclusively Breastfed in Delivery Hospital, 2016				65.3%	63.0%	50.9%	46.3%	**48.1%**	Meets/Better							Prevention Agenda Dashboard
7. Ratio of Infants Exclusively Breastfed in Delivery Hospital Black, non-Hispanic to White, non-Hispanic, 2014-2016				N/A	N/A	0.55	0.59	**0.57**	Less than 10							Prevention Agenda Dashboard
8. Ratio of Infants Exclusively Breastfed in Delivery Hospital Hispanic/Latino to White, non-Hispanic, 2014-2016				N/A	N/A	0.57	0.57	**0.56**	Less than 10							Prevention Agenda Dashboard
9. Ratio of Infants Exclusively Breastfed in Delivery Hospital Medicaid to Non-Medicaid Births, 2014-2016				0.87	N/A	0.68	0.59	**0.66**	Meets/Better							Prevention Agenda Dashboard
Quartile Summary for Prevention Agenda Indicators										0	1	0	0	11.1%	0.0%	
Other Indicators																
1. Percentage Preterm Births < 32 weeks of Total Births Where Gestation Period is Known, '14-16	1	6	5	1.4%	3.9%	**1.5%**	1.5%	N/A	Meets/Better							Community Health Indicator Reports
2. Percentage Preterm Births 32 to < 37 Weeks of Total Births Where Gestation Period is Known, '14-16	16	16	18	5.7%	7.5%	**7.4%**	7.3%	N/A	Meets/Better							Community Health Indicator Reports
3. Percentage of Total Births with Weights Less Than 1,500 grams, '14-16	1	5	4	1.1%	1.2%	**1.3%**	1.4%	N/A	Meets/Better							Community Health Indicator Reports
4. Percentage of Singleton Births with Weights Less Than 1,500 grams, '14-16	1	3	3	0.8*%	0.9%	**1.0%**	1.0%	N/A	Worse	#VALUE!	#VALUE!	#VALUE!	#VALUE!			Community Health Indicator Reports
5. Percentage of Total Births with Weights Less Than 2,500 grams, '14-16	14	19	18	5.7%	6.7*%	**7.6%**	7.9%	N/A	Meets/Better							Community Health Indicator Reports
6. Percentage of Singleton Births with Weights Less Than 2,500 grams, '14-16	10	17	14	4.7%	5.1*%	**5.7%**	6.0%	N/A	Meets/Better							Community Health Indicator Reports
7. Percentage of Total Births for Black, Non-Hispanic, with Weights Less than 2,500 Grams, '14-16				N/A	N/A	**12.9%**	12.2%	N/A	Less than 10							State and County Indicators for Tracking Public Health Priority Areas
8. Percentage of Total Births for Hispanic/Latino, with Weights Less than 2,500 Grams, '14-16				N/A	N/A	**7.5%**	7.7%	N/A	Less than 10							State and County Indicators for Tracking Public Health Priority Areas
9. Infant Mortality Rate per 1,000 Live Births, '14-16	0	0	1	1.1*	5.7*	**5.0**	4.5	N/A	Less than 10							Community Health Indicator Reports
10. Rate of Deaths (28 Weeks Gestation to < Seven Days) per 1,000 Live Births and Perinatal Deaths, '14-16	1	0	0	3.1*	3.5*	**5.3**	5.1	N/A	Less than 10							Community Health Indicator Reports
11. Percentage Early Prenatal Care of Total Births Where Prenatal Care Status is Known, '14-16	220	239	180	71.4%	75.4%	**77.0%**	75.2%	N/A	Worse	X						Community Health Indicator Reports
12. Percentage Early Prenatal Care for Black, Non-Hispanic, '14-16				N/A	N/A	**68.5%**	64.5%	N/A	Less than 10							State and County Indicators for Tracking Public Health Priority Areas
13. Percentage Early Prenatal Care for Hispanic/Latino, '14-16				N/A	N/A	**71.1%**	76.7%	N/A	Less than 10							State and County Indicators for Tracking Public Health Priority Areas
14. Percentage APGAR Scores of Less Than Six at Five Minute Mark of Births Where APGAR Score is Known, '14-16	3	6	2	1.2%	1.1%	**0.9%**	0.7%	N/A	Worse		X					Community Health Indicator Reports
15. Rate of Newborn Drug Related Hospitalizations per 10,000 Births, '13-15				106.1	110.9	**140.8**	104.8	N/A	Meets/Better							Community Health Indicator Reports

16. Percentage WIC Women Breastfeeding for at least 6 months, '14-16				23.6%	N/A	**30.7%**	40.3%	N/A	Worse	X						Community Health Indicator Reports
17. Percentage Infants Receiving Any Breast Milk in Delivery Hospital, '14-16	186	207	185	85.1%	79.5%	**82.9%**	87.3%	N/A	Meets/Better							Community Health Indicator Reports
Quartile Summary for Other Indicators										2	1	0	0	17.6%	0.0%	
Quartile Summary for Focus Area Maternal and Infant Health										2	2	0	0	13.8%	0.0%	

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score	
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4			
Focus Area: Preconception and Reproductive Health																
Prevention Agenda Indicators																
1. Percent of Births within 24 months of Previous Pregnancy, 2016				23.4%	23.2%	22.5%	19.8%	**17.0%**	Worse		X					Prevention Agenda Dashboard
2. Rate of Pregnancies Ages 15 - 17 year per 1,000 Females Ages 15-17, 2016				14.7	11.1	9.9	13.3	**25.6**	Less than 10							Prevention Agenda Dashboard
3. Ratio of Pregnancy Rates for Ages 15 - 17 Black, non-Hispanic to White, non-Hispanic, 2014-2016				N/A	N/A	4.30	4.80	**4.40**	Less than 10							Prevention Agenda Dashboard
4. Ratio of Pregnancy Rates for Ages 15 - 17 Hispanic/Latino to White, non-Hispanic, 2014-2016				N/A	N/A	3.50	4.40	**4.10**	Less than 10							Prevention Agenda Dashboard
5. Percent of Unintended Pregnancies among Total Births, 2016				33.7%	32.9%	24.9%	22.6%	**23.8%**	Worse		X					Prevention Agenda Dashboard
6. Ratio of Unintended Pregnancies Black, non-Hispanic to White, non-Hispanic, 2016				N/A	N/A	2.08	2.12	**1.90**	Less than 10							Prevention Agenda Dashboard
7. Ratio of Unintended Births Hispanic/Latino to White, non-Hispanic, 2016				N/A	N/A	1.49	1.68	**1.43**	Less than 10							Prevention Agenda Dashboard
8. Ratio of Unintended Births Medicaid to Non-Medicaid, 2016				1.10	N/A	1.96	1.71	**1.54**	Meets/Better							Prevention Agenda Dashboard
9. Percentage of Women Ages 18- 64 with Health Insurance, 2016				95.2%	N/A	N/A	93.1%	**100.0%**	Worse	X						Prevention Agenda Dashboard
Quartile Summary for Prevention Agenda Indicators										1	2	0	0	33.3%	0.0%	
Other Indicators																
1. Rate of Total Births per 1,000 Females Ages 15-44, '14-16	298	336	265	52.1	53.2	**57.2**	58.5	N/A	Meets/Better							Community Health Indicator Reports
2. Percent Multiple Births of Total Births, '14-16	9	6	10	2.8%	3.5%	**4.0%**	3.7%	N/A	Meets/Better							Community Health Indicator Reports
3. Percent C-Sections to Total Births, '14-16	104	103	92	33.3%	34.1%	**34.2%**	33.5%	N/A	Meets/Better							Community Health Indicator Reports
4. Rate of Total Pregnancies per 1,000 Females Ages 15-44, '14-16	361	421	335	58.8	64.5	**72.8**	83.8	N/A	Meets/Better							Community Health Indicator Reports
5. Rate of Births Ages 10 - 14 per 1,000 Females Ages 10-14, '14-16	1	0	0	0.4*	0.2*	**0.2**	0.2	N/A	Less than 10							Community Health Indicator Reports
6. Rate of Pregnancies Ages 10 - 14 per 1,000 Females Ages 10-14, '14-16	1	1	0	0.7*	0.3*	**0.4**	0.6	N/A	Less than 10							Community Health Indicator Reports
7. Rate of Births Ages 15 - 17 per 1,000 Females Ages 15-17, '14-16	10	11	10	14.4	12.5	**11.0**	15.1	N/A	Worse		X					Community Health Indicator Reports
8. Rate of Births Ages 15 - 19 per 1,000 Females Ages 15-19, '14-16	26	18	18	20.5	19.3	**13.2**	14.6	N/A	Worse			X				Community Health Indicator Reports
9. Rate of Pregnancies Ages 15 - 19 per 1,000 Females Ages 15-19, '14-16	32	32	25	26.8	28.1	**22.3**	29.8	N/A	Worse	X						Community Health Indicator Reports
10. Rate of Births Ages 18 - 19 per 1,000 Females Ages 18-19, '14-16	19	12	10	38.8	36.3*	**22.9**	25.6	N/A	Worse			X				Community Health Indicator Reports
11. Rate of Pregnancies Ages 18 - 19 per 1,000 Females Ages 18-19, '14-16	22	21	15	49.6	50.4	**37.5**	50.1	N/A	Worse		X					Community Health Indicator Reports
12. Percent Total Births to Women Ages 35 Plus, '14-16	44	57	39	15.6%	11.7%	**20.2%**	22.1%	N/A	Meets/Better							Community Health Indicator Reports
13. Rate of Abortions Ages 15 - 19 per 1000 Live Births, Mothers Ages 15-19, '14-16				333.3	434.5	**652.3**	990.8	N/A	Meets/Better							Community Health Indicator Reports
14. Rate of Abortions All Ages per 1000 Live Births to All Mothers, '14-16	30	49	45	126.5	181.4	**231.6**	370.9	N/A	Meets/Better							Community Health Indicator Reports
15. Percentage of WIC Women Pre-pregnancy Underweight, '10-12	12	11	11	5.4%	4.9%	**4.1%**	4.7%	N/A	Worse		X					Community Health Indicator Reports
16. Percentage of WIC Women Pre-pregnancy Overweight but not Obese, '10 - 12	45	38	54	21.6%	22.3%	**26.3%**	26.6%	N/A	Meets/Better							Community Health Indicator Reports
17. Percentage of WIC Women Pre-pregnancy Obese, '10 - 12	66	63	55	29.1%	33.3%	**28.0%**	24.2%	N/A	Worse	X						Community Health Indicator Reports
18. Percentage of WIC Women with Gestational Weight Gain Greater than Ideal, '09 - 11	103	105	87	52.9%	52.4%	**47.1%**	41.7%	N/A	Worse	X						Community Health Indicator Reports
19. Percentage of WIC Women with Gestational Diabetes, '09 - 11	14	23	20	9.6%	7.2%	**5.7%**	5.5%	N/A	Worse			X				Community Health Indicator Reports
20. Percentage of WIC Women with Gestational Hypertension, '09 - 11	31	32	23	14.5%	12.9%	**9.1%**	7.1%	N/A	Worse			X				Community Health Indicator Reports
Quartile Summary for Other Indicators										3	3	4	0	50.0%	40.0%	
Quartile Summary for Focus Area Preconception and Reproductive Health										9	4	3	0	55.2%	18.8%	

	Number Per Year (If Available)			Rate, Ratio or Percentage for the Listed	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score	
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4			
Focus Area: Child Health																
Prevention Agenda Indicators																
1. Percentage of Children Ages 0 - 15 Months with Government Insurance with Recommended Well Visits, 2016				88.5%	89.8%	82.8%	80.1%	**91.3%**	Worse	X						Prevention Agenda Dashboard
2. Percentage of Children Ages 3 - 6 Years with Government Insurance with Recommended Well Visits, 2016				82.6%	84.9%	82.3%	84.3%	**91.3%**	Worse	X						Prevention Agenda Dashboard
3. Percentage of Children Ages 12 -21 Years with Government Insurance with Recommended Well Visits, 2016				64.0%	69.5%	66.5%	68.1%	**67.1%**	Worse	X						Prevention Agenda Dashboard
4. Percentage of Children Ages 0 -19 with Health Insurance, 2016				96.9%	N/A	N/A	97.4%	**100.0%**	Worse	X						Prevention Agenda Dashboard
Quartile Summary for Prevention Agenda Indicators										4	0	0	0	100.0%	0.0%	
Other Indicators																
1. Rate of Children Deaths Ages 1 - 4 per 100,000 Population Children, '14-16	0	0	0	0.0*	26.8	**19.4**	18.2	N/A	Less than 10							Community Health Indicator Reports
2. Rate of Children Deaths Ages 5 - 9 per 100,000 Population Children, '14-16	0	0	0	0.0*	9.0	**9.7**	10.0	N/A	Less than 10							Community Health Indicator Reports
3. Rate of Children Deaths Ages 10 - 14 per 100,000 Population Children, '14-16	0	0	0	0.0*	15.5	**11.5**	11.4	N/A	Less than 10							Community Health Indicator Reports
4. Rate of Children Deaths Ages 5 - 14 per 100,000 Population Children, '14-16	0	0	0	0.0*	12.3	**10.6**	10.7	N/A	Less than 10							Community Health Indicator Reports
5. Rate of Adolescent Deaths Ages 15 - 19 per 100,000 Population Children, '14-16	0	0	1	15.3*	36.7	**32.6**	31.1	N/A	Less than 10							Community Health Indicator Reports
6. Rate of Asthma Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2016				N/A	N/A	**27.4**	43.5	N/A	Less than 10							Community Health Indicator Reports
7. Rate of Asthma Hospitalizations Children Ages 5 - 14 per 10,000 Population Children, 2016				0.0*	N/A	**9.5**	18.7	N/A	Less than 10							Community Health Indicator Reports
8. Rate of Asthma Hospitalizations Children Ages 0 - 17 per 10,000 Population Children, 2016				N/A	N/A	**12.9**	23.5	N/A	Less than 10							Community Health Indicator Reports
9. Rate of Gastroenteritis Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2016				0.0*	N/A	**8.1**	10.6	N/A	Less than 10							Community Health Indicator Reports
10. Rate of Otitis Media Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2016				0.0*	N/A	**24.4**	2.2	N/A	Less than 10							Community Health Indicator Reports
11. Rate of Pneumonia Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2016				N/A	N/A	**24.4**	30.9	N/A	Less than 10							Community Health Indicator Reports
12. Rate of ED Asthma Visits Children Ages 0 - 4 per 10,000 Population Children, 2016				60.4*	65.5	**105.8**	186.4	196.5	Less than 10							Asthma Dashboard-County Level
13. Percentage of Children born in 2013 Screened for Lead by Age 0-8 months, 2013				1.0*%	0.7%	**1.2%**	1.9%	N/A	Less than 10							Community Health Indicator Reports
14. Percentage of Children Born in 2013 Screened for Lead by Age 9 17 months, 2013				73.3%	77.5%	**71.7%**	74.8%	N/A	Meets/Better							Community Health Indicator Reports
15. Percentage of Children Born 2013 Screened for Lead by Age 36 months (at least two screenings), 2013				56.0%	63.7%	**55.9%**	62.8%	N/A	Meets/Better							Community Health Indicator Reports
16. Rate of Children Ages < 6 with Confirmed Blood Lead Levels >= 10 mg/dl Cases Per 1,000 Children Tested, '14-16	4	0	2	5.1*	11.4	**8.3**	4.3	N/A	Less than 10							Community Health Indicator Reports
17. Rate of Unintentional Injury Hospitalizations for Children Under Age 10 per 10,000 Population Children, 2016				N/A	N/A	**18.1**	18.9	N/A	Less than 10							Community Health Indicator Reports
18. Rate of Unintentional Injury Hospitalizations for Children Ages 10 - 14 per 10,000 Population Children, 2016				N/A	N/A	**12.5**	13.6	N/A	Less than 10							Community Health Indicator Reports
19. Rate of Unintentional Injury Hospitalizations for Children/Young Adults Ages 15 - 24 per 10,000 Population, 2016				14.4*	N/A	**23.1**	23.1	N/A	Less than 10							Community Health Indicator Reports
20. Rate of Asthma ED Visits for Children Ages 0 - 17 per 10,000 Population Children, 2016				55.7	N/A	**68.1**	137.1	N/A	Meets/Better							Asthma Summary Report
21. Percentage of Medicaid Enrollees Ages 2 - 20 with at Least One Dental Visit within the last year, '15-17	1,306	1,375	1,406	47.9%	48.0%	**48.0%**	47.5%	N/A	Worse	X						Community Health Indicator Reports
22. Percentage of 3rd Graders with Dental Caries, '09 - 11				50.4%	N/A	N/A	N/A	N/A	Meets/Better							Community Health Indicator Reports
23. Percentage of 3rd Graders with Dental Sealants, '09 - 11				34.5%	N/A	N/A	N/A	N/A	Meets/Better							Community Health Indicator Reports

24. Percentage of 3rd Graders with Dental Insurance, '09 - 11			86.6%	N/A	N/A	N/A	N/A	Meets/Better							Community Health Indicator Reports
25. Percentage of 3rd Graders with at Least One Dental Visit, '09 - 11			76.8%	N/A	N/A	N/A	N/A	Meets/Better							Community Health Indicator Reports
26. Percentage of 3rd Graders Taking Fluoride Tablets Regularly, '09 - 11			85.4%	N/A	N/A	N/A	N/A	Meets/Better							Community Health Indicator Reports
27. Rate of Caries Outpatient Visits for Children Ages 3 - 5 per 10,000 Population, 2016			221.3	164.1	**119.7**	90.0	N/A	Worse				X			Community Health Indicator Reports
28. Percentage of WIC Children Ages 2 - 4 Viewing Two Hours TV or Less Per Day, '14-16			87.0%	85.7%	**85.0%**	85.3%	N/A	Worse	X						Community Health Indicator Reports
Quartile Summary for Other Indicators									2	0	0	1	10.3%	33.3%	
Quartile Summary for Focus Area Child Health									6	0	0	1	21.2%	14.3%	

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score	Source
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4			
Focus Area: Human Immunodeficiency Virus (HIV)																
Prevention Agenda Indicators																
1. Rate of Newly Diagnosed HIV Cases per 100,000 Population, 2014-2016				3.9*	N/A	**6.9**	16.0	16.1	Less than 10							Prevention Agenda Dashboard
2. Ratio of Newly Diagnosed HIV Cases Black, non-Hispanic versus White, non-Hispanic, 2014-2016				-3.3	N/A	**20.1**	35.2	46.8	Less than 10							Prevention Agenda Dashboard
Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%	
Other Indicators																
1. Rate of AIDS Cases per 100,000 Population, '14-16				2.3*	N/A	**3.3**	7.7	N/A	Less than 10							Community Health Indicator Reports
2. Rate of AIDS Deaths per 100,000 Adjusted Population, '14-16	0	0	0	0.0*	N/A	**1.1**	3.0	N/A	Less than 10							Community Health Indicator Reports
Quartile Summary for Other Indicators										0	0	0	0	0.0%	0.0%	
Quartile Summary for Focus Area Human Immunodeficiency Virus (HIV)										0	0	0	0	0.0%	0.0%	

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score	
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4			
Focus Area: Sexually Transmitted Disease (STDs)																
Prevention Agenda Indicators																
1. Rate of Primary and Secondary Syphilis for Males per 100,000 Male Population, 2016				0.0*	3.3	9.1	24.3	**10.1**	Less than 10							Prevention Agenda Dashboard
2. Rate of Primary and Secondary Syphilis for Females per 100,000 Female Population, 2016				0.0*	0.6	0.5	1.3	**0.4**	Less than 10							Prevention Agenda Dashboard
3. Rate of Gonorrhea Cases for Females Ages 15-44 per 100,000 Female Population Ages 15-44, 2016				17.7*	60.6	197.1	206.2	**183.4**	Less than 10							Prevention Agenda Dashboard
4. Rate of Gonorrhea Cases for Males Ages 15 - 44 per 100,000 Male Population Ages 15-44, 2016				13.6*	48.2	230.0	452.5	**199.5**	Less than 10							Prevention Agenda Dashboard
5. Rate of Chlamydia for Females Ages 15 - 44 per 100,000 Female Population Ages 15 - 44, 2016				689.5	1170.1	1351.6	1620.7	**1458.0**	Meets/Better							Prevention Agenda Dashboard
Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%	
Other Indicators																
1. Rate of Early Syphilis Cases per 100,000 Population, '14-16	0	0	0	0.0*	2.52*	**7.9**	25.1	N/A	Less than 10							Community Health Indicator Reports
2. Rate of Gonorrhea Cases per 100,000 Population, '14-16	17	27	18	8.6	16.1	**64.6**	111.8	N/A	Meets/Better							Community Health Indicator Reports
3. Rate of Gonorrhea Ages 15 - 19 Cases per 100,000 Population Ages 15-19, '14-16	2	1	0	45.9*	45.8*	**209.9**	305.8	N/A	Less than 10							Community Health Indicator Reports
4. Rate of Chlamydia Cases All Males per 100,000 Male Population, '14-16	16	13	10	173.8	352.5	**569.5**	857.7	N/A	Meets/Better							Community Health Indicator Reports
5. Rate of Chlamydia Cases Males Ages 15 - 19 Cases per 100,000 Male Population Ages 15-19, '14-16	0	1	1	56.9*	403.1	**607.9**	922.5	N/A	Less than 10							Community Health Indicator Reports
6. Rate of Chlamydia Cases Males Ages 20 - 24 per 100,000 Male Population Ages 20-24, '14-16	7	7	4	480.3	779.1	**1,199.7**	1,638.0	N/A	Meets/Better							Community Health Indicator Reports
7. Rate of Chlamydia Cases All Females per 100,000 Female Population, '14-16	40	29	39	626.3	1,188.4	**1,300.3**	1,577.4	N/A	Meets/Better							Community Health Indicator Reports
8. Rate of Chlamydia Cases Females Ages 15- 19 per 100,000 Female Population Ages 15 - 19, '14-16	9	11	13	1,093.1	2,131.7	**2,300.5**	3,147.6	N/A	Meets/Better							Community Health Indicator Reports
9. Rate of Chlamydia Cases Females Ages 20 - 24 per 100,000 Female Population Ages 20-24, '14-16	16	11	16	1,611.0	2,717.9	**2,833.9**	3,424.6	N/A	Meets/Better							Community Health Indicator Reports
10. Rate of PID Hospitalizations Females Ages 15 - 44 per 10,000 Female Population Ages 15 - 44, 2016				0.0*	N/A	**1.9**	2.5	N/A	Less than 10							Community Health Indicator Reports
Quartile Summary for Other Indicators										0	0	0	0	0.0%	0.0%	
Quartile Summary for Sexually Transmitted Diseases										0	0	0	0	0.0%	0.0%	

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score	
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4			
Focus Area: Vaccine Preventable Disease																
Prevention Agenda Indicators																
1. Percent of Children Ages 19 - 35 months with 4:3:1:3:3:1:4, 2016				73.0%	73.9%	64.0%	N/	**80.0%**	Worse	X						Prevention Agenda Dashboard
2. Percent females 13 - 17 with 3 dose HPV vaccine, 2016				34.2%	42.6%	41.7%	N/	**50.0%**	Meets/Better							Prevention Agenda Dashboard
3. Percent of Adults Ages 65 Plus With Flu Shots Within Last Year, 2016				57.8%	N/	59.6%	59.5%	**70.0%**	Worse	X						Prevention Agenda Dashboard
Quartile Summary for Prevention Agenda Indicators										2	0	0	0	66.7%	0.0%	
Other Indicators																
1. Rate of Pertussis Cases per 100,000 Population, '13-15	7	2	0	7.8*	11.7	**5.9**	5.1	N/A	Less than 10							Community Health Indicator Reports
2. Rate of Pneumonia/Flu Hospitalizations Ages 65 Plus per 10,000 Population Age 65 Plus, '12-14				98.4	93.3	**93.7**	87.3	N/A	Worse	X						Community Health Indicator Reports
3. Percent of Adults Ages 65 Plus Ever Received a Pneumonia Shot, '13/14				73.7%	75.0%	**73.8%**	69.3%	N/A	Worse	X						NYS Expanded Behavioral Risk Factor Surveillance System
4. Rate of Mumps Cases per 100,000 Population, '13-15	0	0	1	0.4*	0.09	**0.70**	1.08	N/A	Less than 10							Community Health Indicator Reports
5. Rate of Meningococcal Cases per 100,000 Population, '13-15	0	0	0	0.0*	0.09*	**0.1***	0.1	N/A	Less than 10							Community Health Indicator Reports
6. Rate of H Influenza Cases per 100,000 Population, '13-15	0	3	0	2.6*	2.0	**1.7**	1.5	N/A	Less than 10							Community Health Indicator Reports
Quartile Summary for Other Indicators										2	0	0	0	33.3%	0.0%	
Quartile Summary for Focus Area Vaccine Preventable Diseases										4	0	0	0	44.4%	0.0%	

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score	
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4			
Focus Area: Healthcare Associated Infections																
Prevention Agenda Indicators																
1. Rate of Hospital Onset Clostridium difficile infections (CDIs) per 10,000 Patient Days, 2017				N/A	5.6	N/A	5.2	**5.94**	Less than 10							NYS Department of Health Hospital Report on Hospital Acquired Infections
2. Rate of Community Onset, Healthcare Facility Associated CDIs per 10,000 Patient Days, 2017				N/A	53.8	N/A	29.2	**2.05**	Less than 10							NYS Department of Health Hospital Report on Hospital Acquired Infections
Quartile Summary for Healthcare Associated Infections										0	0	0	0	0.0%	0.0%	

	Number Per Year (If Available)			Average	Comparison Regions/Data					Quartile Ranking						
	One	Two	Three													

	One	Two	Three	Average Rate, Ratio or Percentage for the Listed Years	ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark	Comparison to Benchmark	Q1	Q2	Q3	Q4	Quartile Score	Severity Score	Source
Focus Area: Prevent Substance Abuse and Other Mental, Emtional, and Behavorial Disorders																
Prevention Agenda Indicators																
1. Age-adjusted Percent of Adults Binge Drinking within the Last Month, 2016				24.7%	N/A	19.1%	18.3%	**18.4%**	Worse		X					Prevention Agenda Dashboard
2. Age-adjusted Percent of Adults with Poor Mental Health (14 or More Days) in the Last Month, 2016				14.4%	N/A	11.2%	10.7%	**10.1%**	Worse		X					Prevention Agenda Dashboard
3. Age Adjusted Rate of Suicides per 100,000 Adjusted Population, '14-16				12.9	N/A	9.6	8.0	**5.9**	Worse				X			Prevention Agenda Dashboard
Quartile Summary for Prevention Agenda Indicators										0	2	0	1	100.0%	33.3%	
Other Indicators																
1 Rate of Suicides for Ages 15 - 19 per 100,000 Population Ages 15 - 19, '14-16				0.0*	10.7	**6.1**	5.0	N/A	Less than 10							Community Health Indicator Reports
2. Rate of Self-inflicted Hospitalizations 10,000 Population, 2016				2.4*	N/A	**4.1**	3.5	N/A	Less than 10							Community Health Indicator Reports
3. Rate of Self-inflicted Hospitalizations for Ages 15 - 19 per 10,000 Population Ages 15 - 19, 2016				N/A	N/A	**8.7**	7.6	N/A	Less than 10							Community Health Indicator Reports
4. Rate of Cirrhosis Deaths per 100,000 Population, '14-16				8.7	13.8	**7.4**	8.0	N/A	Worse	X						Community Health Indicator Reports
5. Rate of Cirrhosis Hospitalizations per 10,000 Population, 2016				2.6	1.5	**3.3**	3.0	N/A	Meets/Better							Community Health Indicator Reports
7. Rate of Alcohol-Related Crashes per 100,000, 2017				94.8	69.1	**53.20**	38.0	N/A	Worse				X			NYS Traffic Safety Statistical Repository
8. Rate of Alcohol-Related Injuries and Deaths per 100,000 Population, 2017				31.6	28.8	**10.5**	19.4	N/A	Worse				X			NYS Traffic Safety Statistical Repository
9. Rate of Drug-Related Hospitalizations per 10,000 Population, '12-14	42	43	18	8.8	14.6	**20.3**	24.0	N/A	Meets/Better							Community Health Indicator Reports
10. Rate of People Served in Mental Health Outpatient Settings Ages 17 and under per 100,000 Population Ages 17 and under, 2015				1,437.3	1,279.4	**642.2**	682.2	N/A	Worse				X			NYS Office of Mental Health, PCS Summary Report
11. Rate of People Served in Mental Health Outpatient Settings Ages 18 - 64 per 100,000 Population Ages 18 - 64, 2015				776.6	819.5	**620.5**	689.7	N/A	Worse		X					NYS Office of Mental Health, PCS Summary Report
12. Rate of People Served in Mental Health Outpatient Settings Ages 65+ per 100,000 Population Ages 65+, 2015				62.5	141.7	**170.3**	311.4	N/A	Meets/Better							NYS Office of Mental Health, PCS Summary Report
13. Rate of People Served in Emergency Settings for Mental Health Ages17 and under per 100,000 Population Ages under 17 and under, 2015				N/A	15.6	**20.0**	18.9	N/A	Less than 10							NYS Office of Mental Health, PCS Summary Report
14. Rate of People Served in Emergency Settings for Mental Health Ages 18 - 64 per 100,000 Population Ages 18 - 64, 2015				N/A	21.7	**20.0**	25.7	N/A	Less than 10							NYS Office of Mental Health, PCS Summary Report
15. Rate of People Served in Emergency Settings for Mental Health Ages 65+ per 100,000 Population Ages 65+, 2015				N/A	N/A	**5.7**	7.6	N/A	Less than 10							NYS Office of Mental Health, PCS Summary Report
Quartile Summary for Other Indicators										1	1	0	3	33.3%	60.0%	
Quartile Summary for Focus Area: Prevent Substance Abuse and Other Mental, Emotional, and Behavorial Disorders										1	3	0	4	44.4%	50.0%	

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score	Source
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4			
Other Non-Prevention Agenda Indicators																
1. Rate of Hepatitis A Cases per 100,000 Population, '14-16	0	0	1	0.9*	0.3*	**0.4**	0.5	N/A	Less than 10							Community Health Indicator Reports
2. Rate of Acute Hepatitis B Cases per 100,000 Population, '14-16	0	0	0	0.0*	0.0*	**0.3**	0.5	N/A	Less than 10							Community Health Indicator Reports
3. Rate of TB Cases per 100,000 Population, '14-16	1	0	0	0.9*	0.5*	**1.8**	3.9	N/A	Less than 10							Community Health Indicator Reports
4. Rate of e. Coli Shiga Toxin Cases per 100,000 Population,'14-16	1	1	0	1.7*	2.0	**2.0**	1.6	N/A	Less than 10							Community Health Indicator Reports
5. Rate of Salmonella Cases per 100,000 Population, '14-16	9	3	4	13.9	12.0	**12.0**	11.6	N/A	Worse	X						Community Health Indicator Reports
6. Rate of Shigella Cases per 100,000 Population, '14-16	0	0	0	0.0*	0.4	**2.5**	3.9	N/A	Less than 10							Community Health Indicator Reports
7. Rate of Lyme Disease Cases per 100,000 Population,'14-16	32	45	75	131.9	63.9	**N/A**	38.0	N/A	Meets/Better							Community Health Indicator Reports
8. Rate of Confirmed Rabies Cases per 100,000 Population, 2015				3.7	7.3	**3.3**	1.8	N/A	Worse	X						Department of Health, Wadsworth Center
Quartile Summary for Non-Prevention Agenda Issues										2	0	0	0	25.0%	0.0%	

Appendix 3: ARHN Community Profile Data Sheets

Part A: Demographic Profile

Adirondack Rural Health Network	County									ARHN	Upstate	New York State
Summary of Demographic Information	**Clinton**	**Essex**	**Franklin**	**Fulton**	**Hamilton**	**Montgomery**	**Saratoga**	**Warren**	**Washington**	**Region**	**NYS**	
Square Miles[1,2]												
Total Square Miles[1]	1,037.9	1,794.2	1,629.1	495.5	1,717.4	403.0	810.0	867.0	831.2	8,372.2	46,823.75	47,126.4
Total Square Miles for Farms[1]	230.0	85.7	226.6	49.8	3.2	205.3	123.2	14.9	295.9	906.1	11,223.6	11,224.3
Percent of Total Square Miles Farms	22.2%	4.8%	13.9%	10.1%	0.2%	50.9%	15.2%	1.7%	35.6%	10.8%	24.0%	23.8%
Population per Square Mile [2]	78.12	21.24	30.94	108.64	2.64	122.26	280.32	74.48	74.35	42.5	239.4	418.9
Population[5]												
Total Population	81,224	38,233	51,054	53,955	4,646	49,500	226,632	64,701	62,183	355,996.0	11,238,156	19,798,228
Percent White, Non-Hispanic	91.0%	92.8%	82.5%	94.7%	97.9%	88.2%	93.2%	96.0%	98.5%	92.8%	79.8%	63.8%
Percent Black, Non-Hispanic	4.2%	3.2%	5.9%	1.8%	2.6%	1.8%	1.7%	1.2%	3.4%	3.3%	9.2%	15.7%
Percent Hispanic/Latino	2.8%	3.2%	3.4%	2.8%	1.5%	13.2%	3.0%	2.4%	2.6%	2.8%	10.9%	18.8%
Percent Asian/Pacific Islander, Non-Hispanic	1.5%	0.5%	0.6%	0.7%	0.4%	0.8%	2.8%	1.1%	0.5%	0.8%	3.9%	8.3%
Percent Alaskan Native/American Indian	0.2%	0.2%	6.9%	0.3%	1.0%	0.1%	0.2%	0.2%	0.2%	1.2%	15.2%	8.7%
Percent Multi-Race/Other	1.5%	3.3%	3.9%	2.4%	2.5%	9.1%	2.0%	1.6%	2.2%	2.3%	16.3%	10.7%
Number Ages 0-4	3,827	1,538	2,478	2,270	148	3,054	11,787	2,902	3,051	16,214	616,519	1,176,877
Number Ages 5-14	8,388	3,544	5,493	6,322	377	6,273	26,831	6,892	6,845	37,861	1,347,307	2,300,490
Number Ages 15-17	2,411	1,373	2,041	2,049	131	1,999	8,830	2,354	2,271	12,630	444,834	725,937
Number Ages 18-64	53,326	23,602	33,133	33,062	2,708	29,322	141,813	39,426	38,982	224,239	6,989,413	12,586,573
Number Ages 65+	13,028	8,176	7,909	9,802	1,282	8,852	37,371	13,127	11,034	64,358	1,840,083	3,008,351
Number Ages 15-44 Female	14,990	13,125	8,289	9,272	569	8,805	41,090	10,793	10,096	67,134	2,091,141	4,027,930
Family Status[5]												
Number of Households	31,680	15,257	18,956	22,535	19,700	1,095	93,129	27,249	23,988	159,365	4,160,305	7,302,710
Percent Families Single Parent Households	9.9%	7.9%	10.8%	10.7%	11.3%	n/a	6.7%	7.8%	9.3%	9.7%	9.9%	8.9%
Percent Households with Grandparents as Parents	12.5%	24.8%	5.2%	12.1%	5.4%	9.7%	15.2%	9.2%	8.6%	10.7%	27.3%	19.6%
Poverty[5,3]												
Mean Household Income	$ 65,435	$ 69,488	$ 62,870	$ 61,941	$ 64,039	$ 62,118	$ 96,086	$ 76,756	$ 65,798	$ 66,618	n/a	$ 93,443
Per Capita Income	$ 25,833	$ 29,008	$ 24,294	$ 26,298	$ 24,891	$ 25,307	$ 39,653	$ 33,127	$ 26,064	$ 27,377	$ 40,926	$ 35,752
Percent of Individuals Under Federal Poverty Level	15.7%	8.9%	19.4%	16.0%	9.7%	19.6%	6.6%	9.9%	12.8%	13.9%	11.7%	15.1%
Percent of Individuals Receiving Medicaid	23.2%	20.4%	24.6%	25.0%	22.6%	29.7%	12.7%	18.8%	25.1%	22.9%	43.1%	24.8%
Per Capita Medicaid Expenditures[3]	$ 8,574	$ 8,028	$ 7,383	$ 9,148	$ 7,060	$ 9,069	$ 8,397	$ 8,283	$ 8,493	n/a	n/a	$ 9,670
Immigrant Status[5,4]												
Percent Born in American Territories	95.4%	96.9%	95.3%	97.9%	97.1%	96.4%	94.5%	96.3%	97.8%	96.5%	87.7%	76.0%
Percent Born in Other Countries	4.6%	3.1%	4.7%	2.1%	2.9%	3.6%	5.5%	3.7%	2.2%	3.5%	12.3%	24.0%
Percent Speak a Language Other Than English at Home[4]	5.5%	5.9%	7.5%	3.3%	5.6%	14.3%	6.9%	5.2%	3.3%	5.1%	31.2%	30.6%
Housing[5]												
Total Housing Units	36,352	26,114	25,582	29,004	8,885	23,480	103,766	39,559	29,367	194,863	4,164,398	8,255,911
Percent Housing Units Occupied	87.1%	58.4%	74.1%	77.7%	12.3%	83.9%	89.7%	68.9%	81.7%	72.2%	57.0%	88.5%
Percent Housing Units Owner Occupied	68.0%	76.0%	72.9%	71.4%	84.7%	68.9%	71.5%	71.9%	72.7%	71.8%	74.7%	54.0%
Percent Housing Units Renter Occupied	32.0%	24.0%	27.1%	28.6%	15.3%	31.1%	28.5%	28.1%	27.3%	28.2%	38.7%	46.0%
Percent Built Before 1970	45.2%	57.5%	54.2%	64.6%	55.9%	72.8%	34.2%	46.9%	55.8%	53.3%	92.2%	68.0%
Percent Built Between 1970 and 1979	14.6%	10.5%	11.6%	9.7%	11.6%	7.7%	14.1%	11.9%	10.8%	11.7%	70%	10.0%
Percent Built Between 1980 and 1989	14.7%	11.0%	12.1%	8.8%	11.0%	6.8%	16.2%	14.6%	11.6%	12.3%	74.1%	7.6%
Percent Built Between 1990 and 1999	13.5%	8.9%	12.5%	8.9%	11.9%	6.8%	15.2%	11.9%	9.9%	11.1%	75.3%	6.1%
Percent Built 2000 and Later	12.0%	12.2%	9.8%	8.0%	9.6%	5.7%	20.2%	14.7%	11.9%	11.6%	69.9%	8.2%
Availability of Vehicles[5]												
Percent of Households with No Vehicles Available	9.3%	7.5%	9.5%	9.4%	4.8%	12.7%	4.4%	9.0%	6.3%	8.5%	19.2%	29.0%
Percent of Households with One Vehicle Available	33.6%	32.7%	35.0%	36.5%	31.9%	34.4%	31.9%	35.4%	33.7%	34.5%	58.4%	32.8%
Percent of Households with Two Vehicles Available	37.1%	40.7%	40.1%	37.2%	47.5%	34.7%	43.6%	38.0%	39.3%	38.6%	82.1%	26.2%
Percent of Households with Three or More Vehicles Available	19.9%	19.2%	15.4%	16.9%	15.8%	18.2%	20.0%	17.7%	20.7%	18.4%	89.4%	12.0%
Education[5]												
Total Population Ages 25 and Older	55,125	28,866	35,862	38,651	3,604	34,126	160,285	47,642	44,765	254,515	7,690,861	13,660,809
Percent with Less than High School Education	13.3%	9.1%	13.7%	13.0%	12.2%	14.8%	6.1%	8.3%	11.6%	11.6%	10.0%	13.9%
Percent High School Graduate/GED	37.1%	33.3%	37.2%	35.7%	32.0%	35.3%	24.8%	32.9%	39.2%	36.0%	28.0%	26.3%
Percent Some College, No Degree	17.9%	20.2%	18.6%	20.0%	23.5%	19.3%	17.1%	18.6%	18.7%	18.9%	17.4%	15.9%
Percent Associate's Degree	9.9%	10.7%	11.8%	13.6%	12.2%	13.6%	11.6%	11.0%	10.7%	11.2%	10.4%	8.7%
Percent Bachelor's Degree	11.2%	14.5%	9.0%	9.8%	8.7%	10.1%	23.3%	15.6%	11.6%	11.9%	18.7%	19.9%
Percent Graduate or Professional Degree	10.6%	12.2%	9.6%	7.9%	11.3%	6.9%	17.0%	13.7%	8.2%	10.4%	15.5%	15.4%
Employment Status[5]												
Total Population Ages 16 and Older	68,228	32,769	42,189	44,129	4,079	39,440	185,143	54,254	51,620	297,268	9,126,563	16,080,981
Total Population Ages 16 and Older in Armed Forces	26	10	9	7	1	39	1,563	6	50	109	20,938	23,203
Total Population Ages 16 and Older in Civilian Workforce	38,304	18,796	21,744	26,241	2,243	23,696	122,689	34,150	30,756	172,234	5,737,902	10,152,999
Percent Unemployed	3.2%	3.8%	4.2%	4.5%	6.2%	4.4%	3.0%	3.0%	3.9%	3.7%	3.8%	4.3%
Employment Sector[5]												
Total Employed	36,091	17,544	19,960	24,239	1,991	21,956	117,053	32,518	28,741	161,084	5,394,792	9,467,631
Percent in Agriculture, Forestry, Fishing, Hunting, and Mining	2.3%	3.2%	3.1%	0.9%	0.7%	2.2%	0.8%	0.6%	4.0%	2.2%	1.0%	0.6%
Percent in Construction	4.8%	8.2%	6.6%	6.4%	18.5%	6.9%	6.1%	6.8%	8.2%	6.8%	6.1%	5.6%
Percent in Manufacturing	12.3%	8.7%	5.0%	12.3%	6.8%	13.6%	10.5%	8.4%	14.0%	10.5%	8.3%	6.2%
Percent in Wholesale Trade	1.8%	1.2%	1.4%	1.8%	4.7%	2.2%	2.4%	2.6%	1.7%	1.9%	2.6%	2.4%
Percent in Retail Trade	13.3%	11.6%	10.5%	15.3%	9.3%	13.9%	12.1%	13.3%	14.3%	13.2%	11.4%	10.6%
Percent in Transportation, Warehousing, Utilities	4.9%	3.2%	2.8%	5.7%	10.4%	5.3%	3.2%	3.8%	4.6%	4.4%	4.5%	5.2%
Percent in Information Services	1.9%	1.7%	1.2%	1.5%	1.3%	1.1%	1.8%	1.4%	0.9%	1.4%	2.2%	2.9%
Percent in Finance	2.8%	3.9%	3.2%	2.9%	2.0%	4.4%	7.0%	5.2%	4.3%	3.7%	7.0%	8.1%
Percent in Other Professional Occupations	5.2%	5.1%	5.5%	7.1%	5.0%	6.7%	11.9%	8.3%	7.4%	6.5%	10.6%	11.8%
Percent in Education, Health Care and Social Assistance	26.7%	29.1%	33.2%	27.2%	22.9%	26.4%	25.1%	26.6%	23.0%	27.1%	28.2%	27.5%
Percent in Arts, Entertainment, Recreation, Hotel & Food Service	10.8%	13.6%	10.4%	7.8%	7.4%	6.5%	8.7%	12.7%	7.8%	10.4%	8.6%	9.6%
Percent in Other Services	3.8%	4.2%	4.3%	4.7%	2.9%	4.1%	3.7%	4.8%	4.2%	4.3%	4.7%	5.0%
Percent in Public Administration	9.6%	6.3%	12.8%	6.3%	8.2%	6.8%	6.6%	5.5%	5.6%	7.6%	5.1%	4.5%

(n/a) Data Not Available

Sources:

(1) US Department of Agriculture, National Agriculture Statistics Service, 2012

(2) NYS Department of Health, Vital Statistics of New York State 2016

(3) Centers for Medicare and Medicaid Services, CMS Enterprise Portal

(4) US Census Bureau, 2010-2014 American Community Survey 5-year Estimates

(5) US Census Bureau, 2013-2017 American Community Survey 5-year Estimates

Part B: Health Systems Profile

Adirondack Rural Health Network	County									ARHN	Upstate NYS	New York
Summary of Health Systems Information	Clinton	Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washington	Region		State
Population, 2013-2017	81,224	38,233	51,054	53,955	4,646	49,500	226,632	64,701	62,183	355,996	11,238,156	19,798,228
Total Hospital Beds[1]												
Hospital Beds per 100,000 Population	369.3	65.4	334.9	137.2	n/a	262.6	75.5	627.5	n/a	274.2	n/a	n/a
Medical/Surgical Beds	214	0	129	47	n/a	70	115	300	n/a	690.0	n/a	n/a
Intensive Care Beds	14	0	14	8	n/a	5	12	12	n/a	48.0	n/a	n/a
Coronary Care Beds	7	0	0	0	n/a	3	7	12	n/a	19.0	n/a	n/a
Pediatric Beds	10	0	3	12	n/a	0	7	14	n/a	39.0	n/a	n/a
Maternity Beds	21	0	13	7	n/a	8	14	23	n/a	64.0	n/a	n/a
Physical Medicine and Rehabilitation Beds	0	0	0	0	n/a	10	0	15	n/a	15.0	n/a	n/a
Psychiatric Beds	34	0	12	0	n/a	20	16	30	n/a	76.0	n/a	n/a
Other Beds	0	25	0	0	n/a	14	0	0	n/a	25.0	n/a	n/a
Hospital Beds Per Facility[1]												
Adirondack Medical Center-Lake Placid Site	-	-	-	-	-	-	-	-	-	-	-	-
Adirondack Medical Center-Saranac Lake Site	-	-	95	-	-	-	-	-	-	-	-	-
Alice Hyde Medical Center	-	-	76	-	-	-	-	-	-	-	-	-
Champlain Valley Physicians Hospital Medical Center	300	-	-	-	-	-	-	-	-	-	-	-
Elizabethtown Community Hospital	-	25	-	-	-	-	-	-	-	-	-	-
Glens Falls Hospital	-	-	-	-	-	-	-	406	-	-	-	-
Nathan Littauer Hospital	-	-	-	74	-	-	-	-	-	-	-	-
Saratoga Hospital	-	-	-	-	-	-	171	-	-	-	-	-
St. Mary's Healthcare	-	-	-	-	-	120	-	-	-	-	-	-
St. Mary's Healthcare-Amsterdam Memorial Campus	-	-	-	-	-	10	-	-	-	-	-	-
Total Nursing Home Beds[2]												
Nursing Home Beds per 100,000 Population	603.3	889.3	381.9	667.2	0.0	1191.9	317.3	616.7	849.1	-	-	-
Nursing Home Beds per Facility[2]												
Alice Hyde Medical Center	-	-	135	-	-	-	-	-	-	-	-	-
Capstone Center for Rehabilitation and Nursing	-	-	-	-	-	120	-	-	-	-	-	-
Champlain Valley Physicians Hospital Medical Center SNF	34	-	-	-	-	-	-	-	-	-	-	-
Clinton County Nursing Home	80	-	-	-	-	-	-	-	-	-	-	-
Elderwood at North Creek	-	-	-	-	-	-	-	82	-	-	-	-
Elderwood at Ticonderoga	-	84	-	-	-	-	-	-	-	-	-	-
Elderwood of Uihlein at Lake Placid	-	156	-	-	-	-	-	-	-	-	-	-
Essex Center for Rehabilitation and Healthcare	-	100	-	-	-	-	-	-	-	-	-	-
Fort Hudson Nursing Center, Inc.	-	-	-	-	-	-	-	-	196	-	-	-
Fulton Center for Rehabilitation and Healthcare	-	-	-	176	-	-	-	-	-	-	-	-
Glens Falls Center for Rehabilitation and Nursing	-	-	-	-	-	-	-	117	-	-	-	-
Granville Center for Rehabilitation and Nursing	-	-	-	-	-	-	-	-	122	-	-	-
Meadowbrook Healthcare	287	-	-	-	-	-	-	-	-	-	-	-
Mercy Living Center	-	-	60	-	-	-	-	-	-	-	-	-
Nathan Littauer Hospital Nursing Home	-	-	-	84	-	-	-	-	-	-	-	-
Palatine Nursing Home	-	-	-	-	-	70	-	-	-	-	-	-
Plattsburgh Rehabilitation and Nursing Center	89	-	-	-	-	-	-	-	-	-	-	-
River Ridge Living Center	-	-	-	-	-	120	-	-	-	-	-	-
Saratoga Center for Rehab and Skilled Nursing Care	-	-	-	-	-	-	257	-	-	-	-	-
Seton Health at Schuyler Ridge Residential Healthcare	-	-	-	-	-	-	120	-	-	-	-	-
Slate Valley Center for Rehabilitation and Nursing	-	-	-	-	-	-	-	-	88	-	-	-
St Johnsville Rehabilitation and Nursing Center	-	-	-	-	-	120	-	-	-	-	-	-
The Pines at Glens Falls Center for Nursing & Rehabilitation	-	-	-	-	-	-	-	120	-	-	-	-
Warren Center for Rehabilitation and Nursing	-	-	-	-	-	-	-	80	-	-	-	-
Washington Center for Rehabilitation and Healthcare	-	-	-	-	-	-	-	-	122	-	-	-
Wells Nursing Home Inc	-	-	-	100	-	-	-	-	-	-	-	-
Wesley Health Care Center Inc	-	-	-	-	-	-	342	-	-	-	-	-
Wilkinson Residential Health Care Facility	-	-	-	-	-	160	-	-	-	-	-	-
Total Adult Care Facility Beds[3]												
Adult Care Facility Beds per 100,000 Population	221.6	928.5	176.3	307.7	0.0	977.8	390.1	452.9	403.6	375.0	550.2	404.7
Total Adult Home Beds	150	194	60	114	n/a	294	483	248	142	908	38,328	49,670
Total Assisted Living Program Beds	30	30	30	52	n/a	160	0	45	69	256	7,072	12,192
Total Assisted Living Residence (ALR) Beds	0	131	0	0	n/a	30	401	0	40	171	16,434	18,255
Adult Home Beds by Total Capacity per Facility[3]												
Adirondack Manor HFA D.B.A Adirondack Manor HFA ALP	-	-	-	-	-	-	-	60	-	-	-	-
Adirondack Manor HFA D.B.A Montcalm Manor HFA	-	40	-	-	-	-	-	-	-	-	-	-
Ahana House	-	-	-	-	-	-	17	-	-	-	-	-
Alice Hyde Assisted Living Program	-	-	30	-	-	-	-	-	-	-	-	-
Argyle Center for Independent Living	-	-	-	-	-	-	-	-	35	-	-	-
Arkell Hall	-	-	-	-	-	24	-	-	-	-	-	-
Beacon Pointe Memory Care Community	-	-	-	-	-	-	52	-	-	-	-	-
Champlain Valley Senior Community	-	81	-	-	-	-	-	-	-	-	-	-
Cook Adult Home	-	-	-	-	-	-	13	-	-	-	-	-
Countryside Adult Home	-	-	-	-	-	-	-	48	-	-	-	-
Elderwood Village at Ticonderoga	-	23	-	-	-	-	-	-	-	-	-	-
Emeritus at the Landing of Queensbury	-	-	-	-	-	-	-	88	-	-	-	-
Hillcrest Spring Residential	-	-	-	-	-	80	-	-	-	-	-	-
Holbrook Adult Home	-	-	-	-	-	-	-	-	33	-	-	-
Home of the Good Shepherd at Highpointe	-	-	-	-	-	-	86	-	-	-	-	-
Home of the Good Shepherd	-	-	-	-	-	-	42	-	-	-	-	-
Home of the Good Shepherd Moreau	-	-	-	-	-	-	72	-	-	-	-	-
Home of the Good Shepherd Saratoga	-	-	-	-	-	-	105	-	-	-	-	-
Home of the Good Shepherd Wilton	-	-	-	-	-	-	54	-	-	-	-	-
Keene Valley Neighborhood House	-	50	-	-	-	-	-	-	-	-	-	-
Pine Harbour	66	-	-	-	-	-	-	-	-	-	-	-
Pineview Commons H.F.A.	-	-	-	94	-	-	-	-	-	-	-	-
Samuel F. Vilas Home	44	-	-	-	-	-	-	-	-	-	-	-
Sarah Jane Sanford Home	-	-	-	-	-	40	-	-	-	-	-	-
The Cambridge	-	-	-	-	-	-	-	-	40	-	-	-
The Farrar Home	-	-	30	-	-	-	-	-	-	-	-	-
The Mansion at South Union	-	-	-	-	-	-	-	-	34	-	-	-
The Sentinel at Amsterdam, LLC	-	-	-	-	-	150	-	-	-	-	-	-
The Terrace at the Glen	-	-	-	-	-	-	-	52	-	-	-	-
Valehaven Home for Adults	40	-	-	-	-	-	-	-	-	-	-	-
Willing Helpers' Home for Women	-	-	-	20	-	-	-	-	-	-	-	-
Woodlawn Commons	-	-	-	-	-	-	42	-	-	-	-	-
Health Professional Shortage Areas (HPSAs)[4,5]												
Number of Primary Care HPSAs[4]	1	8	5	1	2	1	0	3	1	21	111	181

Primary Care HPSA Population[5]	10,339	4,481	5,997	13,950	2,949	11,456	0	2,168	189	40,073	n/a	n/a
Number of Dental Care HPSAs[4]	1	3	5	1	0	1	0	1	1	12	87	139
Dental Care HPSA Population[5]	0	6,368	16,181	0	0	0	0	0	0	22,549	n/a	n/a
Number of Mental Health HPSAs[4]	2	3	2	1	1	1	0	2	2	13	96	159
Mental Care HPSA Population[5]	10,339	39,309	51,698	6,698	4,835	11,456	0	0	0	112,879	n/a	n/a
Population, 2013-2017[5]												
Primary Care Physicians per 100,000 population	119.2	66.2	101.9	99	84.9	83.9	87.5	153	66.4	n/a	102.8	124.1
Subspeciality per 100,000 population												
Obstetrics/Gynecology	14.9	0.0	18.3	7.4	0.0	5.4	8.4	18.6	0.0	n/a	11.0	14.5
IM Subspeciality	34.8	7.0	13.1	9.9	0.0	37.9	21.1	60.0	0.0	n/a	31.8	49.8
General Surgery	6.6	3.5	10.5	9.9	0.0	2.7	3.6	12.4	2.1	n/a	7.9	8.8
Surgical Subspecialties	23.2	10.5	0.0	7.4	0.0	8.1	10.9	37.2	0.0	n/a	17.8	21.6
General Psychiatry	24.8	0.0	15.7	9.9	0.0	8.1	21.1	20.7	8.6	n/a	18.8	36
Other	107.6	20.9	65.3	32.2	56.6	56.9	33.8	159.2	4.3	n/a	87.8	121.1
Total Physician[5]												
Total Physician per 100,000 population	317.9	108.0	206.5	168.3	141.5	200.4	179.2	442.5	81.4	n/a	268.0	362.9
Licensure Data[6]												
Clinical Laboratory Technician	14	6	5	1	0	4	21	9	5	40	1,208	1,649
Clinical Laboratory Technologist	54	19	27	32	1	38	161	50	24	207	7,730	12,064
Dental Assistant	11	2	9	4	0	7	33	10	11	47	1,338	1,435
Dental Hygienist	42	15	16	23	2	26	241	44	38	180	8,035	10,428
Dentist	41	14	17	17	1	25	175	46	15	151	8,771	15,075
Dietition/Nutritionist, Certified	21	9	8	4	1	10	122	22	7	72	3,667	5,492
Licensed Clinical Social Worker (R/P psycotherapy)	42	24	31	21	2	15	266	72	35	227	14,629	25,254
Licensed Master Social Worker (no privileges)	34	22	26	18	2	23	267	53	26	181	14,861	26,884
Licensed Practical Nurse	382	215	321	308	10	362	895	335	438	2,009	48,582	63,082
Physician	211	49	85	59	6	87	528	265	36	711	42,475	75,565
Mental Health Counselor	59	20	32	10	1	13	147	32	13	167	4,647	6,853
Midwife	6	1	3	4	0	2	14	12	5	31	595	1,022
Nurse Practitioner	79	13	36	38	2	27	258	94	29	291	15,282	22,128
Pharmacist	106	29	41	36	2	40	484	64	44	322	13,780	21,306
Physical Therapist	64	40	48	30	3	43	395	67	30	282	13,417	19,277
Physical Therapy Assistant	17	10	18	20	0	26	55	27	16	108	3,988	5,518
Psychologist	11	15	8	10	1	5	109	28	4	77	6,018	11,519
Registered Physician Assistant	43	30	34	21	3	19	199	88	17	236	9,154	13,640
Registered Professional Nurse	1,270	494	744	643	57	714	3,769	1,145	755	5,108	172,978	243,639
Respiratory Therapist	18	3	6	17	0	18	110	21	13	78	4,107	5,763
Respiratory Therapy Technician	6	0	2	2	0	1	12	4	3	17	579	747

(n/a) Data Not Available

Sources:

(1) NYS Department of Health, NYS Health Profiles

(2) NYS Department of Health, Nursing Home Weekly Bed Census, 2018

(3) NYS Department of Health, Adult Care Facility Directory

(4) Health Resources and Services Administration, HPSA Find, 2017-2018

(5) Center for Health Workforce Studies, Health Workforce Planning Data Guide, 2014

(6) NYS Office of the Professions, License Statistics, 2019

Part C: Education System Profile

Adirondack Rural Health Network	County									ARHN		New York
Summary of Education System Information	Clinton	Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washington	Region	Upstate NYS	State
School System Information[1,2,3]												
Total Number of Public School Districts	9	11	8	6	5	6	12	9	12	60	725	733
Total Pre-K Enrollment	250	188	335	377	27	432	399	137	344	1,658	51,063	122,681
Total K-12 Enrollment	10,599	3,618	7,158	7,423	401	7,254	33,329	8,743	8,311	46,253	1,604,870	2,629,970
Number of Students Eligible for Free Lunch	4,410	1,533	3,594	3,504	141	3,869	6,646	3,158	3,511	19,851	592,339	1,263,175
Number of Students Eligible for Reduced Lunch	521	290	471	320	32	310	959	321	477	2,432	69,464	131,974
Percent Free and Reduced Lunch	47.0%	50.0%	57.0%	51.0%	43.0%	57.0%	23.0%	40.0%	48.0%	46.5%	40.0%	53.0%
Number Limited English Proficiency[2]	1,259	636	546	965	75	848	6,718	1,684	1,356	6,521	220,797	437,130
Percent with Limited English Proficiency[2]	42.0%	43.0%	25.0%	33.0%	45.0%	30.0%	55.0%	48.0%	42.0%	13.6%	13.3%	45.0%
Total Number of Graduates	774	273	505	514	27	474	2,531	688	561	3,342	116,704	179,863
Number Went to Approved Equivalency Program	1	0	2	0	n/a	3	9	21	5	29	1,097	2,653
Number Dropped Out of High School	78	18	48	89	n/a	112	176	38	94	365	10,670	21,368
Percent Dropped Out of High School	2.0%	2.0%	2.0%	4.0%	n/a	5.0%	2.0%	1.0%	4.0%	0.8%	0.64%	3.0%
Total Number of Public School Teachers[3]	1,008.9	422.0	701.9	602.8	89.5	627.1	2,277.3	784.2	813.8	4,422.9	132,652.7	209,093.4
Student to Teacher Ratio[3]	10.9	9.1	10.7	13.3	4.9	12.6	13.4	11.4	10.8	10.97	12.37	13.05
Education Programs[4]												
Medical Resident Programs	0	0	0	0	0	0	0	0	0	0	203	967
Medical Resident Graduations/Completions	0	0	0	0	0	0	0	0	0	0	920	5,790
Physician Assistant Programs	0	0	0	0	0	0	0	0	0	0	7	27
Physician Assistant Graduations/Completions	0	0	0	0	0	0	0	0	0	0	103	764
Nurse Practitioner Programs	0	0	0	0	0	0	0	0	0	0	24	58
Nurse Practitioner Graduations/Completions	0	0	0	0	0	0	0	0	0	0	249	725
Pharmacist Programs	0	0	0	0	0	0	0	0	0	0	3	6
Pharmacist Graduations/Completions	0	0	0	0	0	0	0	0	0	0	398	913
Dental Hygienist Programs	0	0	0	0	0	0	0	0	0	0	7	13
Dental Hygienist Graduations/Completions	0	0	0	0	0	0	0	0	0	0	197	429
Licensed Practical Nursing Programs	1	1	0	0	0	1	1	0	0	2	36	52
Licensed Practical Nurse Graduations/Completions	23	23	0	0	0	26	70	0	0	46	2,186	3,369
Registered Nursing Programs	2	2	0	0	0	1	1	1	0	5	68	118
Registered Nurse Graduations/Completions	93	93	0	0	0	32	19	86	0	272	4,606	10,192
Social Worker Programs	0	0	0	0	0	0	0	0	0	0	7	22
Social Worker Graduations/Completions	0	0	0	0	0	0	0	0	0	0	645	3624

(n/a) Data Not Available

Sources:

(1) NYS Education Department, School Report Card Data, 2016-2017

(2) NYS Education Department, 3-8 ELA Assessment Data, 2017-2018

(3) Institute of Education Sciences, National Center for Education Statistics, District Directory Information 2016-2017 School Year Data

(4) Center for Health Workforce Studies, Health Workforce Planning Data Guide, 2014

Adirondack Rural Health Network				
Summary of Education System Information				
School District by County[1]				
Clinton	**Essex**	**Franklin**	**Fulton**	**Hamilton**
Ausable Valley	Crown Point	Brushton-Moira	Broadalbin-Perth	Indian Lake
Beekmantown	Elizabethtown-Lewis	Chateaugay	Gloversville	Inlet
Chazy	Keene	Franklin-Essex-Hamilton BOCES	Johnstown	Lake Pleasant
Clinton-Essex-Warren-Washington BOCES	Lake Placid	Malone	Mayfield	Long Lake
Northeastern Clinton	Minerva	Saint Regis Falls	Northville	Wells
Northern Adirondack	Moriah	Salmon River	Wheelerville	
Peru	Newcomb	Saranac Lake		
Plattsburgh	Schroon Lake	Tupper Lake		
Saranac	Ticonderoga			
	Westport			
	Willsboro			

Montgomery	**Saratoga**	**Warren**	**Washington**
Amsterdam	Ballston Spa	Bolton	Argyle
Canajoharie	Corinth	Glens Falls City	Cambridge
Fonda-Fultonville-Fort Plain	Edinburg	Glens Falls Common	Fort Ann
Hamilton-Fulton-Montgomery BOCES	Galway	Hadley-Luzerne	Fort Edward
Oppenheim-Ephratah-St.Johnsville	Mechanicville	Johnsburg	Granville
	Niskayuna	Lake George	Greenwich
	Saratoga Springs	North Warren	Hartford
	Schuylerville	Queensbury	Hudson Falls
	Shenendehowa	Warrensburg	Putnam
	South Glens Falls		Salem
	Stillwater		Washington BOCES
	Waterford-Halfmoon		Whitehall

*Gray highlighting indicates a regional school district

(n/a) Data Not Available

Sources:

(1) Institute of Education Sciences, National Center for Education Statistics, District Directory Information 2016-2017 School Year Data

Part D: ALICE Profile

ALICE is a United Way acronym that stands for Asset Limited, Income Constrained, Employed.												
Adirondack Rural Health Network	County									ARHN	Upstate NY	NYS
Summary of ALICE Information	Clinton	Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washington			
ALICE Household Information												
Total Households	30,624	15,298	19,299	22,450	1,239	19,540	93,703	28,841	24,027	141,778	4,101,529	7,216,340
Total Households Over 65 Years of Age	8,150	5,144	4,817	6,339	544	5,484	24,083	8,898	6,738	40,630	705,081	1,839,483
Total ALICE Households	7,350	4,589	5,404	6,511	632	6,448	19,678	6,922	7,208	38,615	1,059,036	2,222,633
ALICE Households Over 65 Years of Age	2,119	1,749	1,590	2,282	261	2,468	6,502	2,936	2,291	13,408	380,182	662,214
Poverty %	15.0%	10.2%	18.2%	15.0%	12.2%	17.6%	6.8%	11.0%	12.1%	13.6%	11.3%	14.4%
ALICE %	24.4%	30.1%	27.8%	29.3%	50.7%	33.2%	21.1%	24.0%	30.4%	27.4%	28.7%	30.8%
Above ALICE %	60.6%	59.7%	54.0%	55.7%	37.1%	49.2%	72.1%	65.1%	57.5%	59.0%	60.0%	54.8%
# of ALICE and Poverty Households	12,062	6,161	8,869	9,945	779	9,928	26,181	10,079	10,204	58,099	1,640,619	3,262,043
Unemployment Rate	5.0%	7.5%	8.5%	8.0%	9.2%	8.4%	2.9%	4.6%	8.1%	n/a	n/a	n/a
Percent of Residents with Health Insurance	95.8%	93.2%	91.3%	91.4%	90.4%	91.2%	96.1%	96.5%	91.9%	n/a	n/a	n/a
Average Annual Earnings	$36,372.00	$37,128.00	$35,148.00	$32,892.00	$32,940.00	$37,704.00	$47,604.00	$40,932.00	$38,028.00	n/a	n/a	n/a
ALICE Households by Race/Ethnicity												
White	8,119	4,449	5,191	6,683	622	6,112	19,596	6,635	7,404	39,103	922,506	1,245,865
Asian	50	n/a	2	28	n/a	28	191	65	27	172	31,141	180,688
Black	122	n/a	13	32	n/a	134	255	100	14	281	125,980	433,433
Hispanic	81	33	41	156	n/a	651	425	126	200	637	134,063	494,216
2+ races	95	49	44	71	n/a	79	278	38	64	361	22,672	54,130

*Upstate is all counties in New York, minus the New York City counties (Bronx, Kings, New York, Queens and Richmond).
*Data in all categories except *Two or More Races* is for one race alone. Because race and ethnicity are overlapping categories, the totals for each income category do not add to 100 percent exactly.
(n/a) Data Not Available
Sources:
(1) American Community Survey, 2016.
ALICE Demographics:
(2) American Community Survey and the ALICE Threshold, 2016.
Wages:
(3) Bureau of Labor Statistics, 2016
Budget:
(4) Bureau of Labor Statistics, 2016a; Consumer Reports, 2017; Internal Revenue Service, 2016
(5) New York State Office of Children & Family Services, 2016; Tax Foundation, 2016, 2017; U.S. Department of Agriculture; U.S. Department of Housing and Urban Development

Appendix 4:

Collaborative Committees List

REGIONAL COLLABORTIVE COMMITTEE

Adirondack Health Institute; Adirondack Rural Health Network,
Community Health Assessment Committee

Name	Agency/Role
Heidi Bailey	Adirondack Health – Adirondack Medical Center
Dan Hill	Adirondack Health– Adirondack Medical Center
Tim Lamay	Adirondack Health– Adirondack Medical Center
Mandy Snay	Clinton County Health Department
Susan Allott	Essex County Health Department
Jessica Darney-Buehler	Essex County Health Department
Erin Streiff	Clinton County Health Department
Angela Stuart Palmer	Fulton County Public Health
Kelly Pilkey	Glens Falls Hospital
Dr. Erica Mahoney	Hamilton County Public Health
Tammy Merendo	Nathan Littauer Hospital
J'nelle Oxford	Warren County Health Services
Patty Hunt	Washington County Public Health
Kathy Jo McIntyre	Washington County Public Health
Ginger Carriero	UVMHN - Alice Hyde Hospital
Debra Good	UVMHN - CVPH
Kaitlyn Tentis	UVMHN - CVPH
Alyson Arnold	UVMHN - Elizabethtown Hospital
Amanda Whisher	UVMHN - Elizabethtown Hospital
Courtney Shaler	Adirondack Health institute
Sara Deukmejian	Adirondack Health institute
Colleen McVeigh	Adirondack Health institute
Theresa Paeglow	Adirondack Health institute
Jessica Chanese	Adirondack Health institute
Tom Tallon	Adirondack Health institute

Meeting dates 2018: 7/19 (phone meeting), 7/25, 8/15, 9/12, 10/3, 10/16, 10/30,
Meeting dates 2019: no 2019 dates; Proposed meeting dates 2020: none projected

ESSEX COUTNY HEALTH PARTNER

LOCAL COLLABORATIVE COMMITTEES

Adirondack Health-Adirondack Medical Center, Population Health Committee

Member	Agency/Role
Darci Beiras, MD Chief Medical Officer	Chief Medical Officer: Executive Sponsor
Dave Mader	Chief Nursing Officer
Aaron Kramer	Chief Operating Officer
Robert Laba	Chief Financial Officer
John Esper, MD	Emergency Department Medical Director
Michael Hill, MD	Chief of Surgery
Heidi Bailey, Population Health Manager	Population Health Manager
Ann Marie Tripp	Director of Transitional Care
Linda Savarie	Patient Education Program Director
Dale Cahill	Assistant Vice President, Physician Network
Lisa Tuggle	Director of Primary Care Clinics
Amy Kohanski	Chronic Disease Prevention Coach
Max Brady	Chronic Disease Prevention Coach

Meeting Dates 2018: 6-21-18; 7-12-18; 8-9-18; 9-13-18; 10-19-18; 11-30-18
Meeting Dates 2019: 1-4-2019; 2-22-2019; 4-26-2019; 6-7-2019;
7-16-2019; 9-7-2019; 10-30-2019; 12-4-2019

UVHN- Elizabethtown Community Hospital, Population Health Committee

Member	Agency/Role
Susan Allott	ECHD DPrevS & ECH Board
Julie Tromblee	ECH CNO
Elizabeth Terry	Community member
David Shelmidine	International Paper Manufacturing Excellence Leader & ECH Board
Megan Murphy	Director of Partner Engagement for the ADK ACO & ECH BOard
Rolland Allen	Community member & ECH Board
Kelly Piotrowski	Community member
John Remillard	ECH President
Robert Perkins	Retired NYSEG & ECH Board
Dominic Eisinger, Ph. D	Biomedical research & ECH Board
Margaret Emery-Ginn	Retired clergy & ECH Board

Meeting Dates 2018: None – Committee formed in 2019
Meeting Dates 2019: 2/7, 5/8, 9/18, 12/16
Proposed Meetings 2020: 3/16, June, September, December TBA

Essex County Health Department Public Health Advisory Committee (PHAC)

Member	Agency/Role
Jennifer Newberry	ECHD Director of Patient Services
Linda Beers	ECHD Director of Public Health
Susan Allott	ECHD Director of Preventive Services
Julie Trombley	UVHN-ECH Chief Nursing Officer
Michael Celotti	UVHN-ECH Medical Director, Pediatrician
Mary Halloran	UVHN-Primary Care Physician
Krissy Leerkes	Essex County Office for the Aging, Director
Hannah Smith	ECHD Physical Therapist
Kristen Sayers	NYSDOH District Office; Environmental Health
Frances Filshie	Community Member
Kathy Daggett	Community Member
Terri Morse	Essex County Mental Health, Director
James Monty	Town Supervisor, Town of Lewis
Diane Dodd	Veterinarian
Ann Merkel	Community Member

Meeting Dates 2018: 3/6, 6/6, 9/11, 12/4
Meeting Dates 2019: 3/5, 6/4, 9/10, 12/3
Proposed Meetings 2020: 3/3, 6/2, 9/1, 12/1

Essex County Board of Supervisors, Human Services Sub-Committee

Member	Agency/Role
Krissy Leerkes	Director of Office for the Aging
C. Harrington	Town of Crown Point, Supervisor, Chairmen
N. Merrihew	Town of Elizabethtown, Supervisor, Vice- Chair
R. Politi	Town of North Elba, Supervisor
S. McNally	Town of Minerva, Supervisor
T. Scozzafava	Town of Moriah, Supervisor
J. Giordano	Town of Ticonderoga, Supervisor
J. Monty	Town of Lewis, Supervisor
J. Wilson	Town of Keene, Supervisor
R. Jackson	Town of North Hudson, Supervisor
Terrie Morse	Director of Community Services Board and Essex County Mental Health
Michael Mascarenes	Commissioner Department of Social Services
Linda L. Beers	Director of Public Health

Meeting Dates 2018: 1/8, 2/12, 3/12, 4/9, 5/14, 6/11, 7/9, 8/13, 9/11, 10/9, 11/5, 12/10
Meeting Dates 2019: 1/14, 2/11, 3/11, 4/8, 5/13, 6/10, 7/8, 8/12, 9/9, 10/15, 11/12, 12/9
Proposed Meeting Dates 2020: 1/7-2/10-3/9-4/13-5/11-6/15-7/13-8/10-9/14-10/9-11/9-12/14

Adirondack Community Action Program (ACAP), Human Services Coalition

Member	Agency/Role
Alan R. Jones	Adirondack Community Action Program
Amanda Goodfellow	SUNY Plattsburgh
Amy Gehrig	North County Center for Independence
Amy Putnam	Fidelis
Andrea Whitmarsh	Essex County Health Department
Anne Marie Tripp	Adirondack Health
Cassandra Jones	Alliance for Positive Health
Cecile McVicker	Essex County Department of Social Services
Cindy Bryan	North County Center for Independence
Cindy Cobb	Adirondack Community Action Program
Claire Thayer	Adirondack Community Church
Danielle Lannon	SUNY Plattsburgh Research Foundation
Donna Beal	Mercy Care
Eli Schwartzberg	Champlain Valley Assisted Living
Eric Pasternak	OPWDD
James Hardman	Alzheimer's Association
Jamie Whidden	Will Rogers
Jocelyn Blanchard	AHI-EASE
Jody Leavens	Fidelis Care
Kasey Manning	Southern Adirondack Independent Living
Kathy Scott	SUNY Plattsburgh
Krissy Leerkes	Essex County Office for the Aging
Laura Paradise	Elizabethtown Community Hospital
Lee Vera	SUNY Plattsburgh Research Foundation
Linda Manzo	Alzheimer's Association
Linda Manzo	Alzheimer's Association
Megan Lewis	Independent Living Center of Hudson Valley
Morgan Gibson	Adirondack Community Action Program
Nancy Dougal	Essex County Transportation Department
Patty Todd	Essex Rehab
Rob Alexander	Adirondack Community Action Program
Ruth Strothers	Essex Center
Scott Sayward	OPWDD
Shelia Bridge	Adirondack Community Action Program
Steve Valley	Essex County Mental Health
Traci Ploufe	Mental Health Association in Essex County
Valerie Ainsworth	Mental Health Association in Essex County
Vicki Smith	Elizabethtown Community Hospital

Meeting Dates 2018: 1/11, 3/8 (cancelled), 5/10, 7/12, 9/13, 11/8

Meeting Dates 2019: 1/10 (cancelled), 3/14, 5/9, 7/11, 9/12, 11/21; Meeting Dates 2020: TBA

Essex County Community Service Board

Name	Agency/Role
Charles Harrington	Town Supervisor of Crown Point
Charles Lustig	Retired teacher
Clay Reaser	Retired Professor
David Reynolds	Sheriff
Geoffrey Neu	Business owner
George King	Military
John J Haverlick	Social Worker (private)
Judy Feigenbaum	Social Worker
Kari Lautenschuetz	HAPAC
Linda Beers	Director of Public Health
Sean Ganter	Essex County Mental Health
Sue Ann Caron	Deputy Director of DSS
Terri Morse	Director of CSB and ECMH
Craig Hacker	Pastor
Lynne Macco	OB-GYN Doctor

Meeting dates 2018: 1/10, 2/7, 3/14, 4/11, 5/9, 6/13, 7/11, 9/12, 10/10, 11/14
Meeting dates 2019: 1/9, 2/13, 3/13, 4/10, 5/8, 6/12, 7/10, 9/11, 10/9, 11/13
Proposed meeting dates 2020: 1/8, 2/12, 3/11, 4/8, 5/13, 6/10, 7/8, 9/9, 10/14, 11/18

Appendix 5:

Distributed Focus Group Analysis Report

May 2019

Purpose

The purpose of the Distributed Focus Group initiative was to ask a single broad question across multiple stakeholder groups and to analyze these results with other forms of data collected as part of the 2019 comprehensive Community Health Assessment (CHA).

Design

Essex County Health Department Public Health Unit staff were asked to include the asking of a single question at existing community coalitions/networks/committee stakeholder meetings. These groups are those with which Health Department staff have ongoing relationships and had a meeting scheduled within the first quarter of 2019. Staff documented the name of the group, number of participants, and responses to the question. Hand written responses or responses captured through meeting minutes were then transposed for documentation in a consistent electronic format; one per meeting. In total 5 groups of stakeholders, facilitated by 3 different staff and including 49 stakeholders were surveyed with this single question:

If you could change 1 thing about your community to make it better what would it be?

Significance

This process was trialed as a strategy to provide a wide range of interpretation of the question being asked leading to a wide range of responses that were likely to tap into social determinants of health.

Analysis Process

Data was analyzed to capture the major concept of response phrases to limit phrases to a single word or group of words that best captured the one (1) thing as asked by the question. This one phrase was documented as a list from which a word cloud was created to visually display the results of responses. The word cloud provides a visual design to display the weighted analysis of words or phrases as identified by stakeholders. The larger the word or phrase, the more times this was identified by respondents.

Major Findings

Community Connections, the most common theme, was used to encompass phrases including expanding cultural opportunities, participation in group activities/opportunities, volunteerism and others.

Physical Activity, including expanding opportunities for, changing the culture to be more active, and specific recreational opportunities was a commonly identified theme.

Transportation, as a standalone issue, was common most particularly within one group.

Economics was used to summarize topics such as economic stability, employment opportunities, livable wages and retaining young people.

Resiliency encompasses topics including Adverse Childhood Experiences (ACEs), reducing the need for foster and kinship care and increasing feelings of hope.

Following are these themes by number of times across groups:

- CommunityConnection-8
- PhysicalActivity-7
- Transportation-7
- Economics-4
- SubstanceAbuse-4
- Resiliency-4
- HealthcareAccess-3
- Childcare-3
- Food access-3
- MentalHealth-2
- Data-2

Results Summarized

Following is a summary of the stakeholder group engaged, the originally documented responses and the responses as analyzed by Essex County Health Department to capture the best meaning of the responses.

Research question: If you could change 1 thing about your community to make it better what would it be?

Stakeholder group	Original responses documented	Analyzed response
1/30/2019 Well Fed Collaborative of Essex County 13 people Elizabeth Terry	1. Land bank 2. Transportation 3. Transportation 4. Transportation 5. Transportation 6. Regulations re: services 7. Lack of mental health services 8. Real time comprehensive data analysis & impact of cq on development 9. Substance abuse 10. Childcare (affordable & quality) 11. Childcare 12. Livable wages 13. Economic stability 14. Food access>grocery stores 15. Indoor activity options 16. Retaining young people to live here	1. CommunityConnection 2. Transportation 3. Transportation 4. Transportation 5. Transportation 6. Regulation 7. MentalHealth 8. Data 9. SubstanceAbuse 10. Childcare 11. Childcare 12. Economics 13. Economics 14. FoodAccess 15. PhysicalActivity 16. Economics
2/7/2019 UVHN-ECH Population Health Committee 10 Susan Allott	1. Opportunities that engage young people in exercise. 2. Reduce dependence on drugs, opioids, and all that goes with it. 3. More opportunities for bicycling. 4. Reduce those dependent on substance abuse. 5. See a closer alignment of day to day social activities and medical needs. (ex. Eye testing at the market) 6. Get more people moving through exercise. 7. Beneficial to have more culture; get people involved. 8. More options for all ages, involving the community and gradually change the culture to embrace more activity.	1. PhysicalActivity 2. SubstanceAbuse 3. PhysicalActivity 4. SubstanceAbuse 5. HealthcareAccess 6. PhysicalActivity 7. CommunityConnection 8. PhysicalActivity

2/13/2019 Community Service Board of Essex County 11 Linda Beers	1. Better data 2. Affordable housing 3. Better job opportunities 4. Food for all 5. Increase mental health providers 6. Make informed supports 7. Swimming pool 8. Transportation 9. Beach in Crown Point	1. Data 2. Economics 3. Economics 4. FoodAccess 5. MentalHealth 6. CommunityConnection 7. PhysicalActivity 8. Transportation 9. PhysicalActivity
2/14/2019 ACAP Human Services Coalition 10 Elizabeth Terry	1. Transportation getting to providers 2. Aged friendly health systems 3. Connectivity to services-Removing stigma to get help 4. Improve hope about the future-lack of hope in the community 5. Insulation and loneliness 6. Substance abuse 7. Invitation to classes & services-friendship piece 8. Culture change-congregate meal sites (increase participation) 9. More volunteers instead of writing checks for clubs, etc. 10. Build resilience in Essex County Communities (related to ACES)	1. Transportation 2. HealthcareAccess 3. CommunityConnection 4. Resiliency 5. CommunityConnection 6. SubstanceAbuse 7. CommunityConnection 8. CommunityConnection 9. CommunityConnection 10. Resiliency
2/15/2019 Essex County Breastfeeding Coalition 5 Elizabeth Terry	1. The increase in care for foster and kinship care children 2. The trauma based behaviors in day care setting 3. Transportation issues 4. Lack of OB service and lack of pediatric and GYN providers 5. The lack of certified day care providers 6. Food security/healthy options	1. Resiliency 2. Resiliency 3. Transportation 4. HealthcareAccess 5. Childcare 6. FoodAccess

Discussion

Data collected through the Distributed Focus Group initiative was designed to complement the Stakeholder Survey. While the stakeholder survey was drafted to align with the New York State Prevention Agenda priority areas, this initiative additional information from stakeholders in a broader, free flow fashion. The initiative allowed for discussion and encourage participants to think on the community level not using the words "people" or "health".

Rather than trying to get stakeholders together for a single focus group this technique allowed staff to engage with existing groups to gather input. Staff reported conversations being difficult to capture and that results may be impacted by the flow of conversation among group members; consistent with the typical focus group process.

There were some inconsistencies in data collection as some groups went one by one through members with responses recorded; others had an open free-flow of comments from stakeholders in the group recorded during discussion.

Conclusions

This initiative was meaningful in engaging a broad representation of community stakeholders in the Community Health Assessment process. However, it could benefit from further refining to ensure:

- emphasis on community,
- consistency in delivery,
- consistency in recording of responses and
- a more concrete method to paraphrasing into common themes.

Appendix 6:

Community Survey Analysis Report

May 2019

EXECUTIVE SUMMARY

Purpose

The purpose of the Community Survey was to collect citizen perspectives about community health. In summary that included definitions of health and a healthy community; challenges within the community including health, social and environmental and challenges experienced by individual respondents and their families including social and access to care. Responses are to be integrated as part of the qualitative data that informs the comprehensive Essex County Community Health Assessment (CHA) along with additional qualitative and quantitative data.

Design

The target population of the survey was Essex County residents ages 18 years and older; 31,220 people. The survey was designed at a reading level of grade 7 and took respondents approximately 10 minutes to complete. It was primarily launched electronically on the Survey Monkey platform; paper versions were also available. Efforts were made to reach a wide variety of residents in terms of age, gender and social connections.

Significance

To provide a statistically significant representation of this population a sample size of just over 2,000 would be needed to achieve a desired 95% confidence level with a 4% margin of error. The sample size achieved was 354; considerably below the sample needed. While acknowledged, the results of the survey are still being analyzed and included as a glimpse into resident perspectives, as one piece of information in the comprehensive CHA.

Major Findings

In addition to statistical significance, it is important to consider respondent demographics as relevant to the following data findings as this contributes to perspective. Survey respondents, as compared to demographics of Essex County residents as a whole, were younger, more female and better educated.

When considering categories of factors that contribute to health outcomes [quality of life and longevity], the survey gathered information in areas of Medical Care Challenges, Social and Economic Challenges, Physical Environment Challenges and Health Challenges. Notable upon analysis is the fact that the survey did not capture any information about health behaviors as a group of factors leading to health problems.

The following is a summary of interpreted respondent input:

- Respondents view health as inclusive –physical, mental and social well-being.
- Features of strong, vibrant, healthy communities most commonly identified:
    - Access to healthcare
    - Clean environment
    - Livable wages
    - Affordable housing
    - Good schools
- Health challenges most commonly identified:
    - Substance abuse
    - Access to healthcare services
    - Overweight/obesity
    - Chronic diseases
    - Issues related to aging

- Social challenge most commonly identified:
  - Lack of employment
  - Affordable housing
  - Lack of livable wages
  - Transportation
  - Access to healthy foods
- Environmental health challenges most commonly identified:
  - Vector-borne diseases
  - Stream, river & lake quality
  - Climate change
  - Drinking water quality
  - School safety
- Medical care challenges most commonly identified:
  - None of the above
  - No specialist locally
  - No dental or vision insurance
  - High co-pays or deductibles
  - Unable to afford
- Cancer services identified as lacking or missing most commonly identified:
  - Stress and anxiety resources and treatment
  - Access to affordable prescription/medication coverage
  - Access to alternative healthcare providers
  - Access to financial assistance programs for co-pays and bills
  - Access to clinical trials

Conclusions

Survey respondents identified an inclusive definition of health – physical, mental & social wellbeing.

Features identified as necessary for a strong, healthy and vibrant community were also identified as challenges within the community. Most notably these include access to healthcare, employment/livable wages and affordable housing.

Respondents identified the top 5 health challenges [from a list of 19 offered as options] as substance abuse, access to healthcare, chronic diseases, overweight/obesity and issues related to aging.

Access to healthcare was examined in more detail through the survey and respondents frequently used the "other" option to elaborate on this issue. Common themes related to healthcare access include:

- Specialty Care: issues identified include traveling considerable distances for care, waiting months for appointments and having inadequate time with providers during appointments.
- Affordability: issues identified include paying high co-pays or deductibles, lack of insurance for dental & vision case and lacking of affordable prescription/medication coverage.

New York State Department of health references the County Health Rankings model[1] for understanding modifiable determinants of health. This survey examined perceptions of physical environment, social and economic factors, and clinical care. It is notable that health behaviors, as a group of modifiable factors, and estimated to account for 30% of health outcomes, was not addressed in this survey. This is an area recommended for additional data collection or inclusion in such future surveys.

[1] University of Wisconsin Population Health Institute supported by the Robert Wood Johnson Foundation. County health Rankings Model. http://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model

FULL REPORT

Background

During the 2018 year, when planning data collection for the 2019 Community Health Assessment, the Essex County Health Department identified a gap in direct community member participation. The use of a community survey was identified as a way to bolster qualitative data collection allowing the Department to gain insight about the community's perception of health and factors that contribute to health outcomes.

This level of data collection/inquiry is a standard advanced by the Public Health Accreditation Board. Seeking accreditation, the Essex County Health Department brought this to the regional Community Health Planning Committee meeting facilitated by the Adirondack Rural Health Network, a program of Adirondack Health Institute. This committee, comprised of local health departments, hospitals and community organizations, decided not to pursue a seven-county regional community survey as this was not required by other governing authorities; namely New York State Department of Health or the Internal Revenue Service.

In the fall of 2018, this Department extended an inquiry to neighboring Clinton County Health Department as an accredited health department with previous community survey experience. The Clinton County Health Department shared the survey planned for use in Clinton County. That survey was developed by the Health Department with the University of Vermont Health Network (UVHN); specifically local representatives of the Champlain Valley Physician Hospital (CVPH) and a Network Senior Community Benefit Strategist from the main campus in Burlington, Vermont.

Essex County Health Department (ECHD) reviewed the Community Survey used by the University of Vermont Medical Center and integrated one question from that survey; #2 regarding vision of a healthy community. ECHD also added 1 unique question; #1 regarding a definition of health.

A request was made from ECHD to the Center for Health Workforce Studies at the University of Albany, School of Public Health for input on the draft survey. Valuable points were noted and will be worked into future surveys. However it was decided to use a nearly identical survey to Clinton County to provide regional comparability.

Building upon regional collaboration and comparability efforts, ECHD extended an invitation to Franklin County Health Department to use the same survey; they agreed. This plan resulted in 3 of the 7 Adirondack Rural Health Network counties using a nearly identical community health survey.

The preparation of the Community Survey was completed in December 2018, launched in January 2019 and remained open through March 31, 2019. It was identified as the 2019 Community Health Assessment Essex & Franklin Counties, New York: Community Survey; referred to hereafter as the Community Survey.

Purpose

The purpose of the Community Survey was to gain insight and perceptions from community members regarding their:

- vision of health and a healthy community
- perception of community challenges
  - health
  - social
  - environmental
- reported challenges for themselves or a family member
  - health
  - social
  - not getting needed care.

There was an additional question asking about cancer care to determine perceptions of what specific cancer services are missing in the community at the request of the Cancer Center at UVHN-CVPH. Demographic information collected about survey respondents included gender identification, age, community residence, spoken language, race/ethnicity, education, income elements of disability.

The intention is to analyze this survey data in combination with other qualitative data- a Stakeholder Survey, a distributed focus group question – with quantitative data to better understand contributing factors and health outcomes of Essex County residents.

Design

Sections of the survey are described above in the Purpose Section. It included a total of 17 questions. The survey was refined to read at Grade 7 and used a font size of 12 or greater with the intention of ensuring readability by most. It was developed to be launched on paper and electronically using the Survey Monkey[2] platform.

Distribution

Essex County Health Department developed a Distribution Plan that relied heavily on the support of community partners to: 1) request their own staff complete the survey and 2) share with the community through their social media and website platforms and 3) share through their direct service programs.

Community partners included:

- Essex County Government Center-Board of Supervisors, Transportation, DSS, EMS, Mental Health, Motor Vehicles, Home Health, WIC & Children's Services
- Schools - public and private;
- Healthcare – hospitals, health centers, pharmacies, Planned Parenthood;
- Aging Care Organizations - Office for the Aging, nursing homes, adult care facilities;
- Community Based Organizations – Cornell Cooperative Extension, Families First, Adirondack Community Action program, food pantries, libraries, local law enforcement agencies, Mountain Lake Services.

The Department provided full printed copies for use with senior congregate meal sites, food pantries and others as requested. It also provided electronic ads, social media messages to share, post-cards and tear-away posters for use in distribution by community partners.

Two major print media (Denton Publications and the Plattsburgh Press Republican) ran stories covering the availability of the survey following a press release and presentation at the Essex County Board of Supervisors.

Responses

Collected:

- 437 total
- 361 collected electronically through the original web link to the Survey Monkey survey
- 76 manually collected/entered; of those (76)
  - 68 as paper versions collected from residents; 8 collected by Clinton County Health Department

Exclusions:

- 31 responses excluded from analysis as Partial or Incomplete responses that did not meet "Complete" criteria. For example, a resident may have started a survey but not finished by clicking the "Done" button. This same person may have gone back to the survey & completed the survey by clicking the "Done" button.
- 1 excluded as a Hamilton County resident
- 5 Clinton County residents (and sent to Clinton County Health Department for analysis)
- 46 Franklin County residents (sent to Franklin County Health Department for analysis)

Inclusions: 354 Essex County resident responses were included in the analysis.

[2] Survey Monkey. About Us. https://www.surveymonkey.com/mp/aboutus/?ut_source=footer

Analysis Process

The analysis & interpretation of survey responses was a multi-step process.

Demographic Representation

The information provided by participants categorized as demographics and being questions 10-17 was compared to the latest available data for Essex County as a whole from the US Census Bureau[3]. This contributed to the interpretation of results given a better understanding of the type of people that engaged in the survey.

Primary Survey Inquiries

First, the Survey Monkey analysis function was used to summarize data for each question. This analysis included the number of participants that responded to each question and the percent of responses that number represented.

Second, all responses typed into the "Other (please specify)" field were also pulled out and sorted by ECHD. Responses by question were categorized into common themes. Responses were then reviewed to determine if they were an elaboration on one of the options provided. If so, the response was added as a response for the specific option. In many cases, this caused very limited change in the Survey Monkey analysis as responses per option typically increased by a single, small digit. All other responses remained in a categorized list. These changes were documented in the Community Survey Responses report (from the Survey Monkey Platform) by showing the revised number and percent of responses in new columns & dark blue color for distinction. All remaining "Other (please specify)" responses are documented by theme following each question within that same report.

Then by question, the top 5 responses or the most commonly selected options by question were identified and ranked highest to lowest. The least commonly selected options were also considered for some questions to better understand things that were at the very low end of commonly identified challenges by respondents.

Next, data visualization through charts was used to document for each question the number of response as "(N= #; Skipped=#)" and the most commonly identified responses. In some instances the least commonly identified responses were also included to demonstrate the difference between the most & least topics as selected by respondents.

Data Analysis Display

Primary survey inquiries were questions 1-9. The first two questions about defining health and features of a heathy community did not provide "Other (please specify)" options. This streamlined responses into just those options provided, though did not leave room for input of additional information from respondents. Data is displayed showing all options for these two questions.

Questions 2-5 asked respondents to choose up to five responses. Thus as part of the analysis the top 5 most commonly identified responses are displayed visually in this report. Questions 6-9 asked respondents to select all that apply and responses in this report are displayed to demonstrate the most commonly selected options. It is noteworthy that selections for specific options are much lower for these questions and some respondents skipped these questions. It is interpreted that these decreased responses are due to the fact that the respondent did not find the question applicable to their personal or familial experiences.

Specific to health challenges, the data is displayed to show perceptions of respondents about community health challenges followed by their experience of health challenges for themselves or a family member; out of order of the survey questions. These charts follow the color depiction from the Survey Monkey data results.

[3] US Census Bureau. Quick Facts: Essex County, NY. People.
https://www.census.gov/quickfacts/fact/table/essexcountynewyork/PST045218

Analysis - Demographic Representation

When compared to US Census data for Essex County as a whole, it was found that survey respondents:

- approximately match racial distribution
- approximately match household income levels
- were more female
- were younger and
- better educated than the Essex County's general population.
- Residents of communities with increased social media connections that were able to be engaged to spread the word about the survey were better represented than the general population.

RACE/ETHNICITY

About 94% of respondents were white; aligning with the 94% of white residents in Essex County.

GENDER

About 75% (265/354) of survey respondents identified as female meaning females were over-represented in survey responses given the Essex County population is about 48% female.

AGE

About 60% of respondents were ages 18-64; 40% ages 65 and older. When excluding people 18 and under the remaining Essex County population is roughly 43% ages 18-64 and 57% 65 and older, therefore respondents were more representative of 18-64 than the general population.

LANGUAGE

100% reported English as a primary language. US Census data demonstrates about 6% of Essex County residents speaking a language at home other than English. This sub-population may be under-represented though the indicators are not exactly the same.

EDUCATIONAL ATTAINMENT

About 56% of survey respondents reported an educational attainment of a Bachelor's Degree or higher. US Census data reports the same indicator as about 27%. This reflects a higher representation of this sub-population in the survey results and under representation of those with a lesser educational attainment.

HOUSEHOLD INCOME

~34% reported $50,000-$99,999; falling within the Essex County median income of $55,000.

GEOGRAPHIC REPRESENTATION

Responses were collected from residents in all 18 Essex County towns. However respondents from communities where there was great town involvement and/or community-level social media platforms in which to share the survey experienced a higher representation of respondents when compared to the breakdown of town populations. The Town of Keene was identified as the community with greatest participation.

DISABILITIES

80% did not select any of the 6 options for disabilities or issues related to disabilities. It is interpreted that the following disabilities were reported because 40% of respondents were 65 or older:

- ~10% reported serious difficulty walking or climbing stairs
- ~7% reported being deaf or having difficulty hearing
- because of a physical, mental or emotional condition
    - 6.5% reported serious difficulty in concentrating, remembering or making decisions &
    - 4.8% reported having difficulty doing errands alone, such a visiting a doctor's office or shopping
- ~3% reported being blind or having serious difficulty seeing, even when wearing glasses
- ~2% reported serious difficulty dressing or bathing

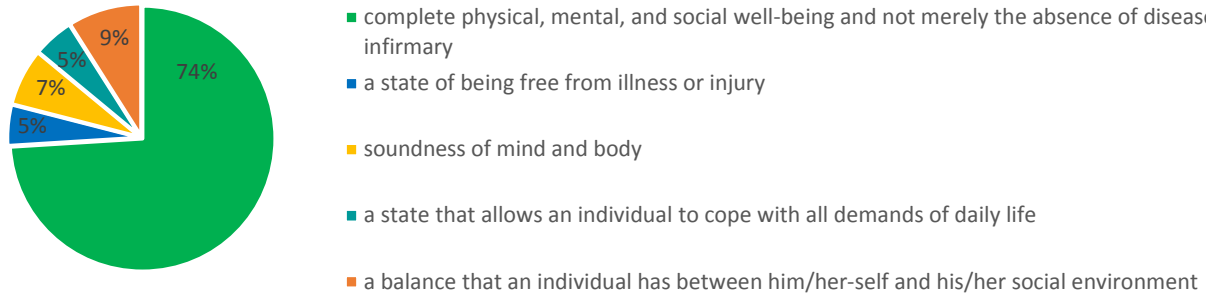
Analysis- Primary Survey Inquiries

DEFINING HEALTH & A HEALTHY COMMUNITY

Health was largely agreed upon as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmary. Results including other options provided are displayed in Figure 1.

Figure 1.

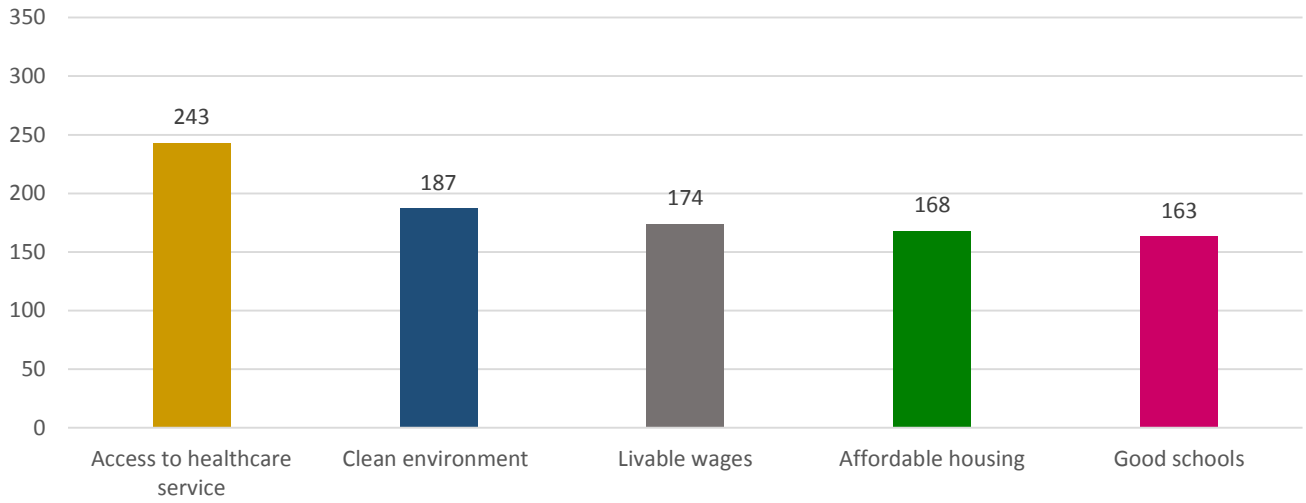
Question 1: Which one definition below best describes what you think of as "health? N=346)



The top 5 [of 17 options] features when imaging a vibrant, healthy community are pictured in Figure 2.

Figure 2.

Question 2: When you imgaine a **strong, vibrant, healthy community**, what are the most important **features** you think of? Choose up to 5 (N=354)



Several of these identified features for a healthy community were also identified as community health challenges throughout the survey responses. These common themes are access to healthcare services, livable wages and affordable housing.

The qualifier of "clean" before environment confounds comparison to the environmental health challenges question though an examination of environmental health challenges is provided later in this report.

Schools were identified here with the qualifier of "good". Schools were also identified in the environmental health challenges section though with the qualifier of "safe". Further investigation as to schools and how the contribute to healthy communities and people is worthy most especially in Essex County where schools are often viewed as the center of communities.

Economic opportunities, though not displayed here, was identified by 142 (40%) of respondents. Further investigation of economic opportunities may help define the meaning of this feature.

Least selected in that offering were Diverse Population (10%), transportation resources (16%) Senior housing (13%), Access to senior services (16%) and Good Childcare (16%).

HEALTH CHALLENGES

The top 5 [of 18 plus Other option] community health challenges are pictured in Figure 3; the top 5 [of 19 plus other option] individual/family health challenges are pictured in Figure 4.

Figure 3.
Question 3: When you think about a **health challenge in the community** where you live, what are you most concerned about? Choose up to 5 (N=354)

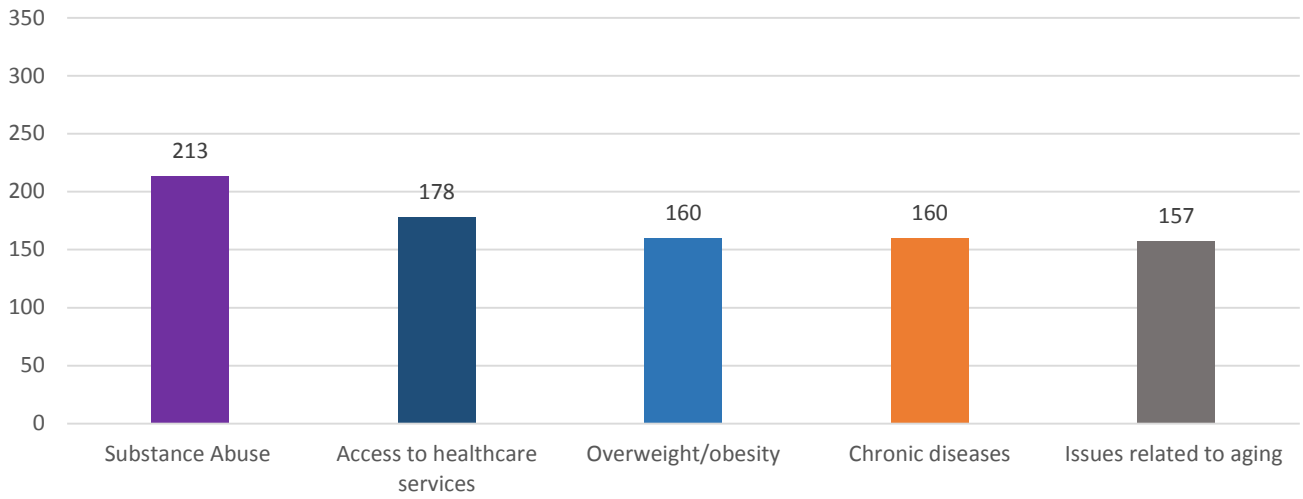
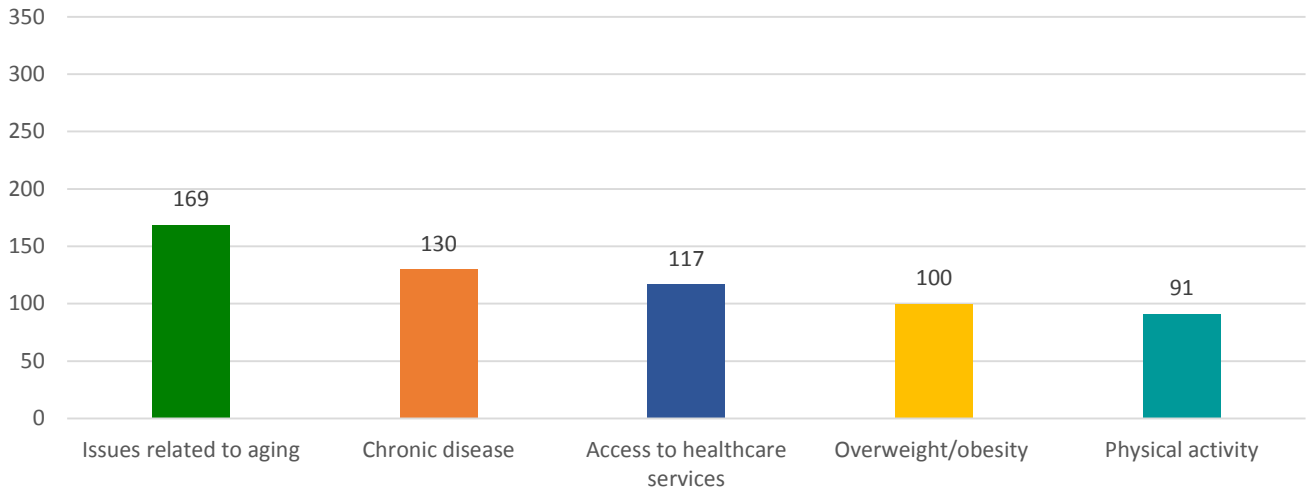


Figure 4.
Question 6: What **health challenges** have **you or a family member** had in the past year? Select all that apply (N=350; Skipped=4)



Four (4) of the 5 identified challenges within the community are fairly well aligned with challenges respondents identified for themselves or family members. Notably, the counts of respondents identified these issue in the community is considerably higher than those identifying the issue for themselves or family member.

Least selected in that offering all under 10% were Immunization rates (4%), Sexually transmitted diseases (4%), Infectious Disease (7%), Lung disease (8%), Intellectual or developmental disabilities (8%).

Given 40% of respondents were ages 65 and older and the age distribution of Essex County residents (as comparably older), it is reasonable that 48% of respondents identified issues related to aging for themselves or a family member.

Access to healthcare services is an issue that has been ongoing across time in Essex County. Considerable changes in the systems of healthcare delivery system may be improving access to care, however residents continue to experience challenges related to life in a rural location including no local provider and long travel distances for specialty care, and issues related to provider shortages including long waits for appointments and reported rushed or brief healthcare visits. It is anticipated that access to healthcare will continue to be a priority issue in Essex County.

SOCIAL CHALLENGES

The top 5 (22 options + Other) community social challenges are pictured in Figure 5; individual/family social challenges in Figure 6.

Figure 5.
Question 4: When you think about **social challenges in the community** where you live, what are you most concerned about? Choose up to 5 (N=354)

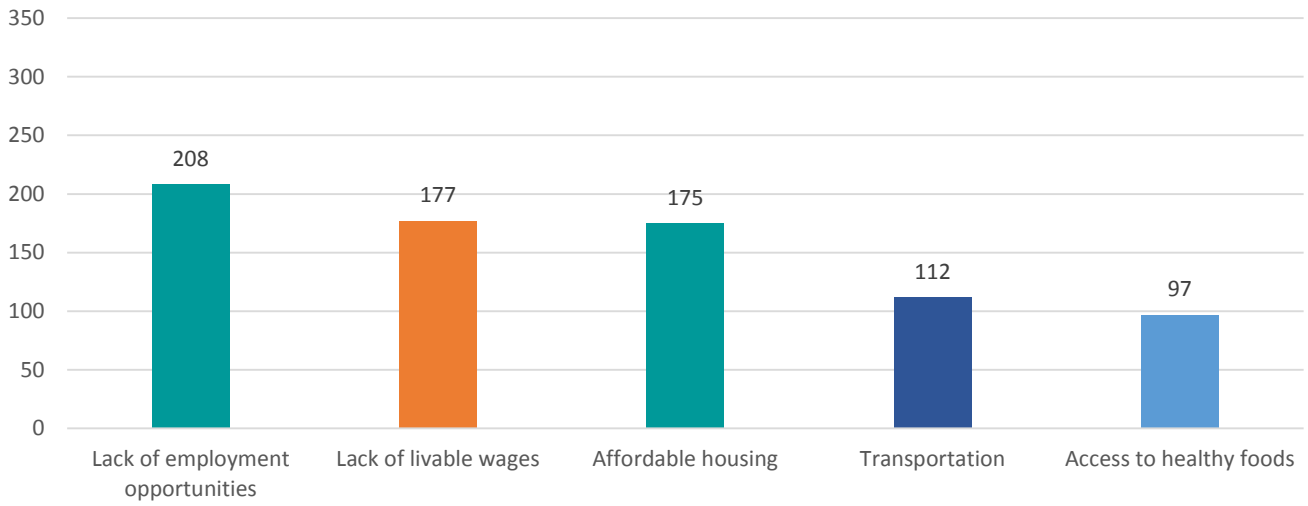
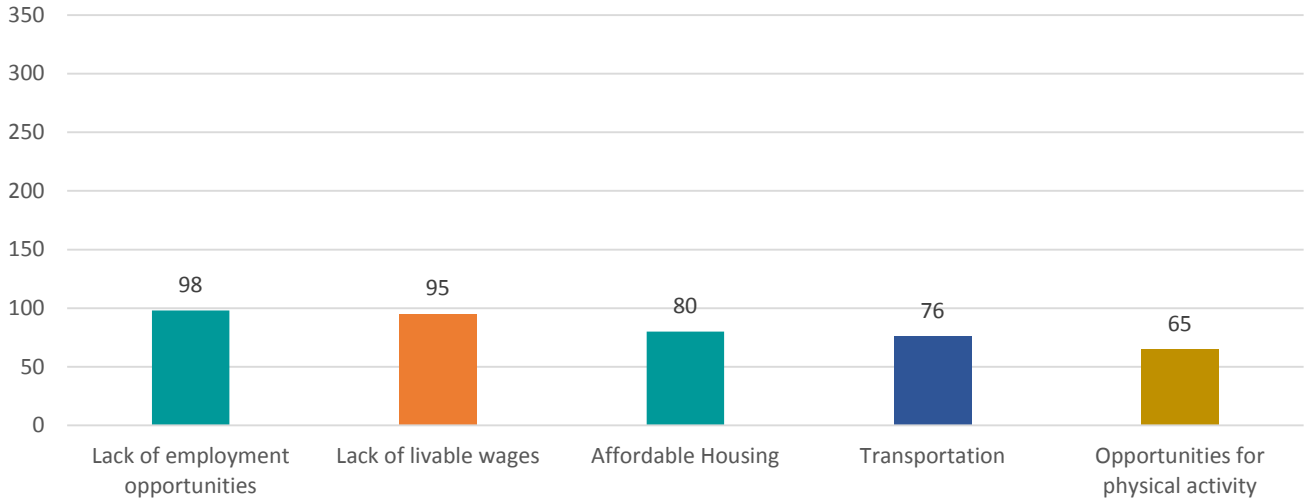


Figure 6.
Question 7: What **social challenges** have **you or a family member** had in the past year? Select all that apply (N=349; Skipped=5)



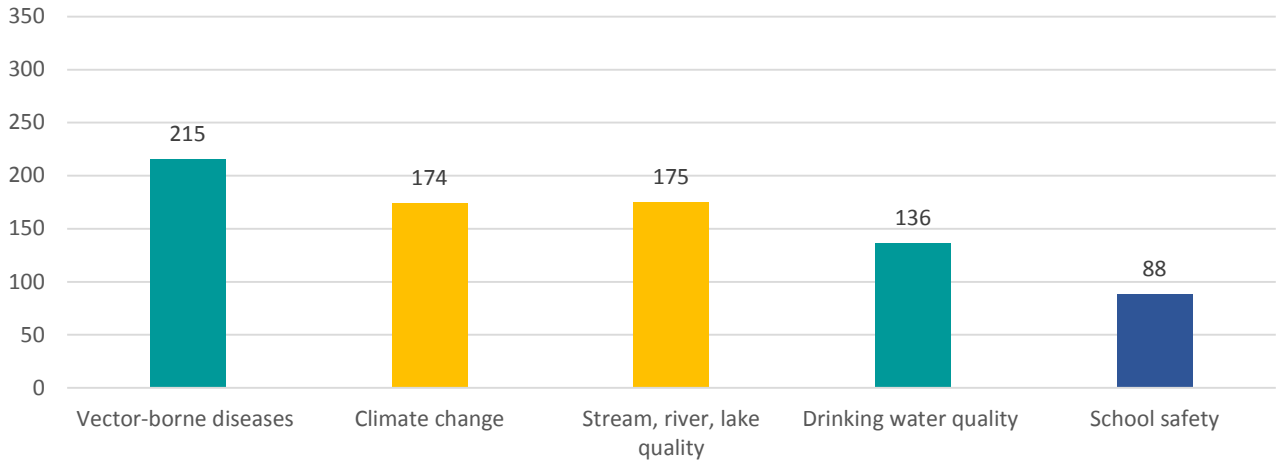
The identified lack of employment opportunities, lack of livable wages, affordable housing and transportation as both community, and to a lesser extent individual respondents & their families, are worthy of further investigation to understand reasons for these perceptions.

Several comments were included in the "Other (please specify)" category regarding the lack of social connectivity or fear of discrimination based on sexual identity or preferences. These responses were not added to the provided option of Racial or cultural discrimination, though capture other forms of real or perceived discrimination. This is an area for inclusion in future surveys to better understand the impact in the Essex County Community.

ENVIRONMENTAL CHALLENGES IN THE COMMUNITY

The top 5 [of 14 plus other options] environmental challenges are pictured in Figure 7.

Figure 7.
Question 5: When you think about **environmental challenges** in the community where you live, what are you most concerned about?
Choose up to 5 (N=354)



Vector-borne diseases was a stand-out in environmental health challenges with several respondents using the other option to elaborate on concerns related to Lyme disease in this question or others. Tick-borne diseases are known through quantitative data analysis to be increasing thus matching closely data and community perception. Efforts will continue to be directed to prevention and early detection of tick-borne diseases as work of this local health department and provider partners.

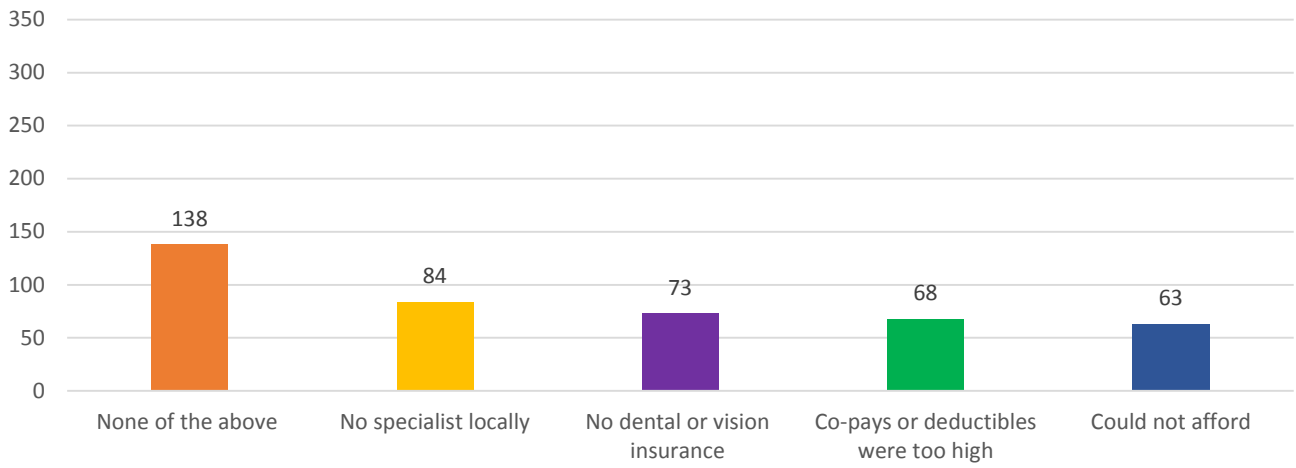
Climate change is an issue of local, national and global concern thereby not surprising to be identified as a community environmental health issue. Essex County has signed on as a Climate Smart Community and there are other educational opportunities being provided by community based organizations. The connection of climate change to human health and work in this area is an area of anticipated growth most especially for local health departments.

Water quality was identified by respondents as stream, river, lake and drinking water. Several comments included concerns about road treatment with salt. Further investigation regrading this concern would need to be conducted to better capture circumstances impacting water quality.

MEDICAL CARE ACCESS

The top 5 (15 options + Other) reasons for not getting medical care when needed are pictured in Figure 8.

Figure 8.
Question 8: If there was a time in the past year that you or a family member needed medical care but could not get it, **why did you not get care**?
Select all that apply (N=353; Skipped=1)



Though access to healthcare was identified as a health challenge in Essex County, the question related to reasons for the respondent or a family member not getting care identified may need further investigation.

The "None of above" option was the most frequent Response at 138 and 41 respondents selected the "Other (please specify)" option. Further review of these other responses contributed to the remainder of most commonly identified issues as depicted in Figure 8.

Expected reasons – not having a doctor, not having child care or not able to leave work – were all under 30 responses.

Issues such as not having access to a specialist locally or having to travel distances for care are expected in rural areas. However other issues respondents identified all have to do with affordability due to lack of dental or vision insurance, high co-pays or deductibles or an inability to afford. Additional comments included extensive waiting times for specialty care appointments with 3 months or greater being identified multiple times. This is consistent with the provider shortages experienced in Essex County and regionally.

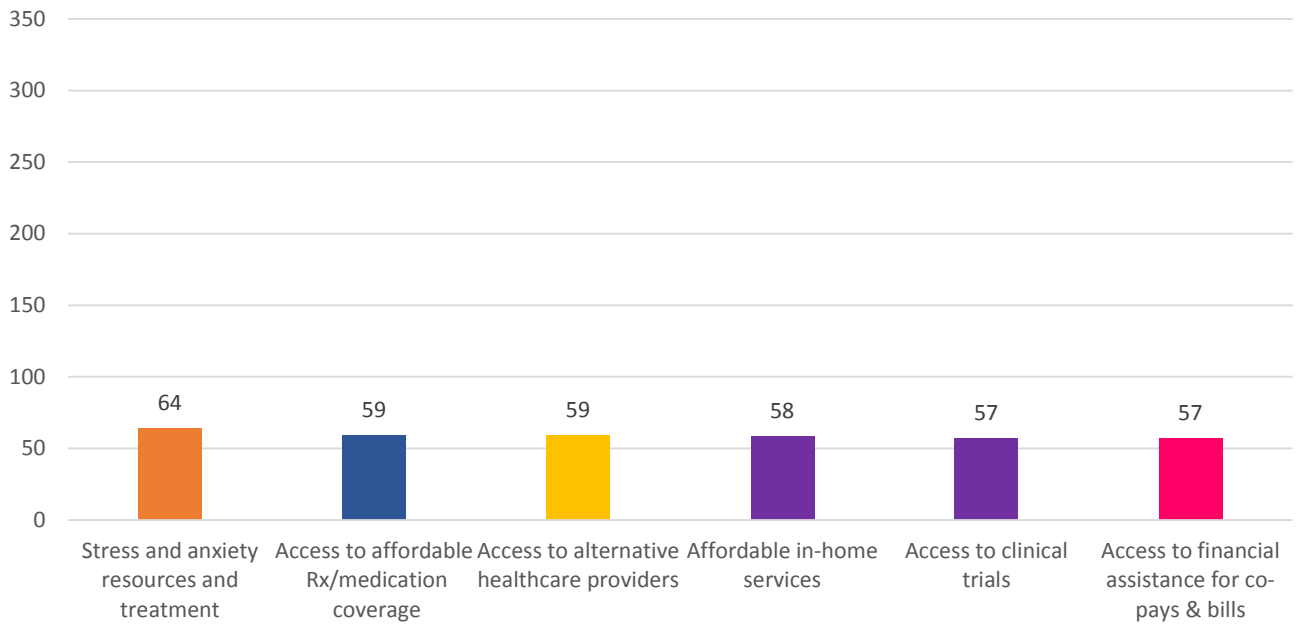
It is anticipated that access to healthcare will continue as a priority issue of Essex County though work in this area will be ever evolving.

CANCER CARE SERVICES MISSING OR LACKING

Notably fewer participants engaged in answering this question with only 264 compared to the total response group of 354. This is interpreted as respondents not having personal or familial cancer care issues therefore not answering the question. The top responses were all somewhat similar in numbers and are depicted here in Figure 9.

Given cancer, as a chronic disease, is an ongoing priority in Essex County issues related to cancer care are important for residents. While public health efforts will focus on prevention and early detection, healthcare providers and systems will continue to work on advancing access to cancer care services as identified here.

Figure 9.
Question 9: Select the **cancer services you feel are missing or lacking** in the community based in your experience. Select all that apply. (N=264; Skipped=90)



Limitations and Considerations

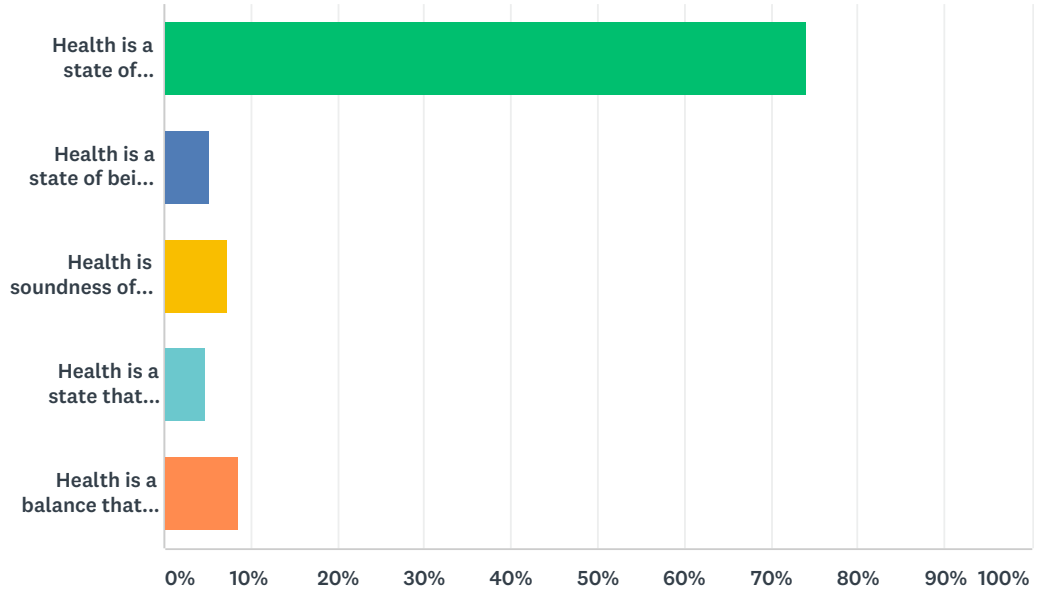
Improved understanding of community perspectives may best be captured in future surveys by integrating the limitations and considerations identified through the analysis of this full report and the general items below.

- Small sample size reduces confidence in drawing conclusions representative of the greater Essex County community; increasing participation in future surveys will improve reliability of data.
- Behaviors were not addressed in the survey though account for approximately 30% of health outcomes. Future surveys or investigations of behaviors, supports and impediments for behaviors are recommended.
- Questions most frequently allowed respondents to select up to 5 options thereby creating a more dispersed response result. Limiting responses to 3 or further refining responses will help identify stand-out issues.
- Some options within questions, though not all, included qualifiers such as "good", "access to" "lack of" or "opportunities for" which confounds understanding of options for the survey taker. Questions that limit the use of or consistently use qualifiers will allow more clear interpretation for survey readers and analyzers.
- "Other (please specify)" was often used to elaborate on a response or provide general comments. Refining the capture of elaboration and comments aside from the capture of actual other responses is recommended.

Community Survey Responses

Q1 Which one definition below best describes what you think of as "health"? Select one.

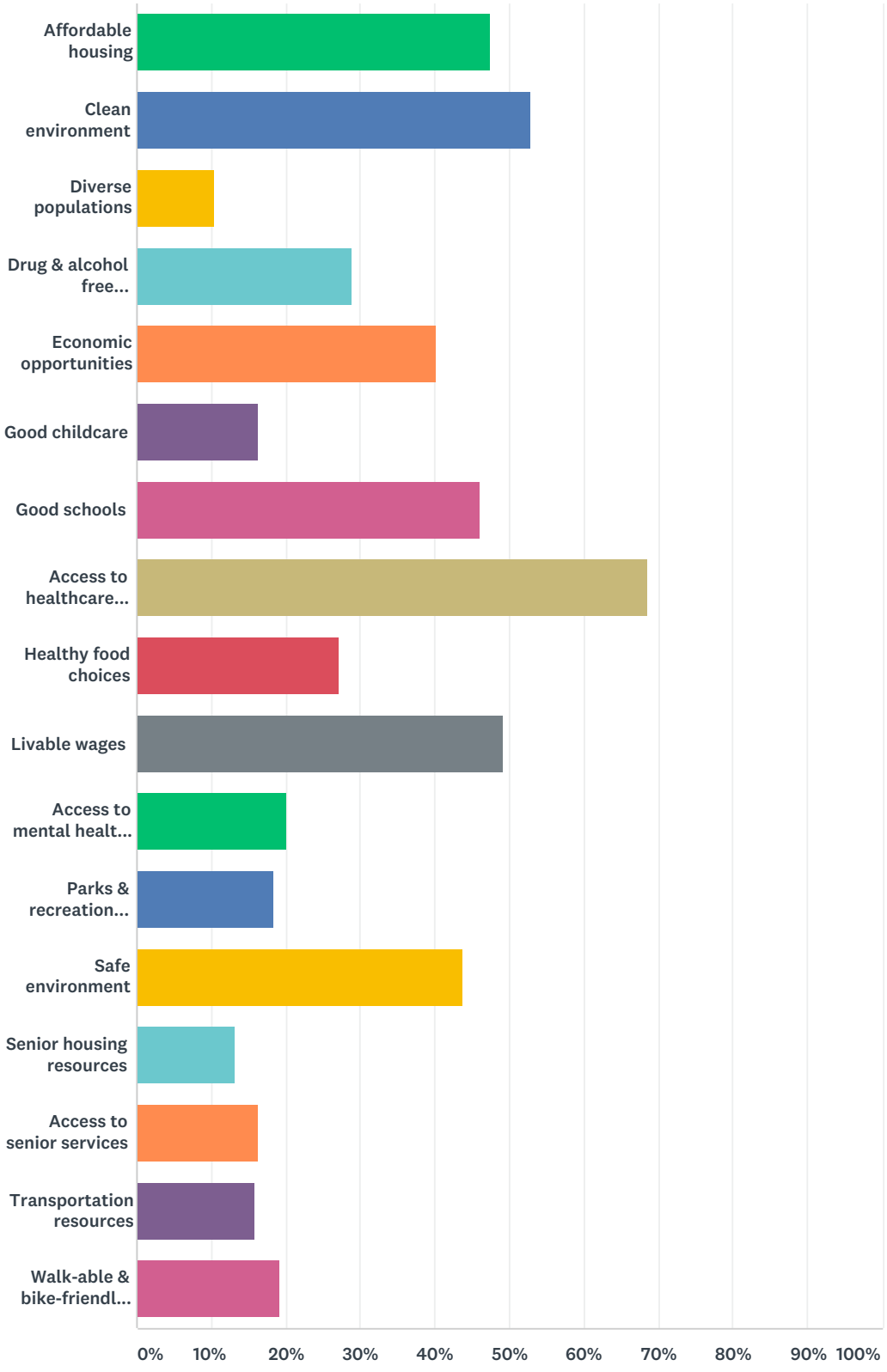
Answered: 346 Skipped: 8



ANSWER CHOICES	RESPONSES	
Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.	73.99%	256
Health is a state of being free from illness or injury.	5.20%	18
Health is soundness of mind and body	7.23%	25
Health is a state that allows an individual to cope with all demands of daily life.	4.91%	17
Health is a balance that an individual has between him/herself and his/her social and physical environment.	8.67%	30
TOTAL		346

Q2 When you imagine a strong, vibrant, healthy community, what are the most important features you think of? Choose up to 5

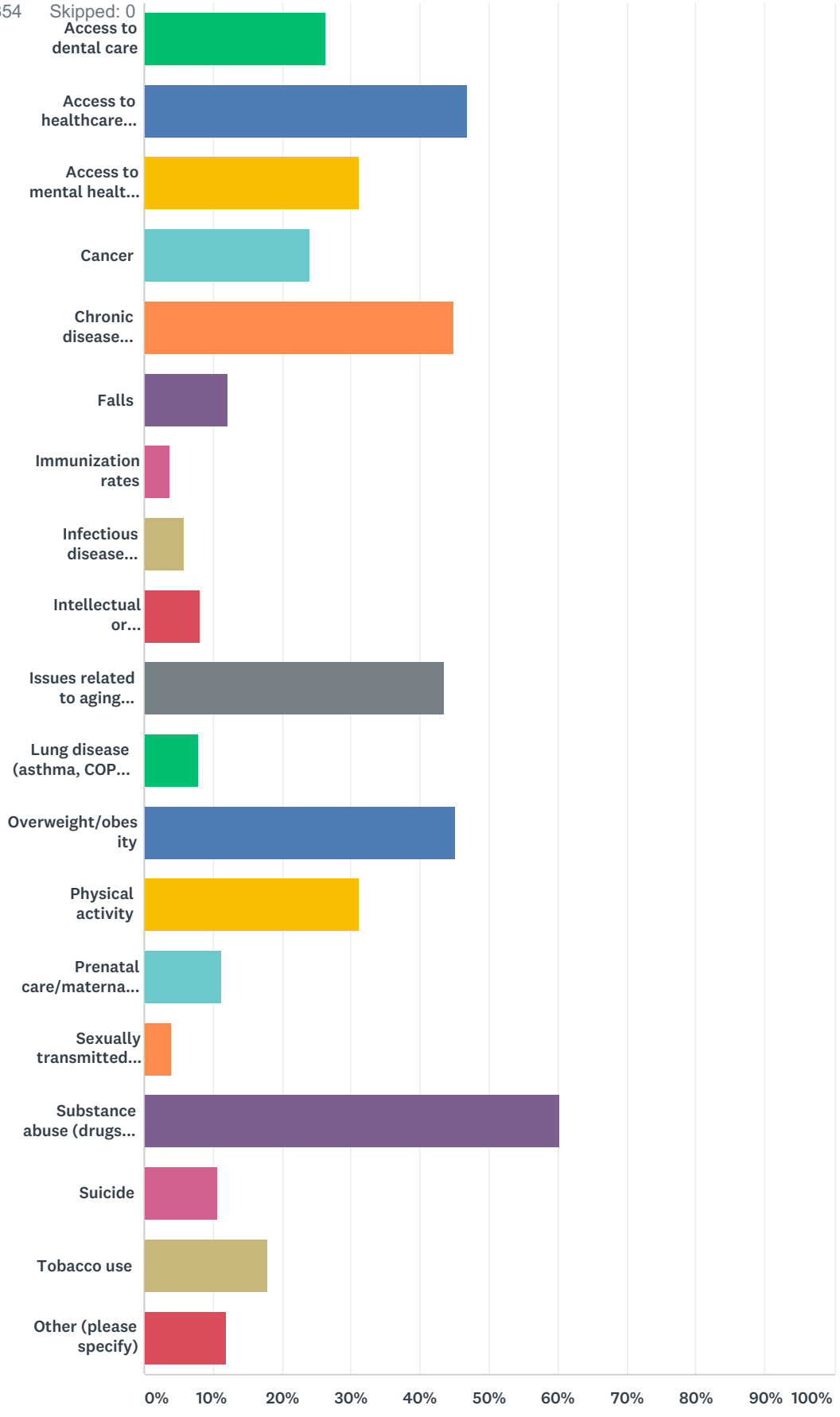
Answered: 354 Skipped: 0



	RESPONSES	
Affordable Housing	47.46%	168
Clean environment	52.82%	187
Diverse populations	10.45%	37
Drug & alcohol free communities	28.81%	102
Economic opportunities	40.11%	142
Good childcare	16.38%	58
Good schools	46.05%	163
Access to healthcare services	68.64%	243
Healthy food choices	27.12%	96
Livable wages	49.15%	174
Access to mental health services	20.06%	71
Parks & recreation resources	18.36%	65
Safe environment	43.79%	155
Senior housing resources	13.28%	47
Access to senior services	16.38%	58
Transportation resources	15.82%	56
Walk-able & bike-friendly communities	19.21%	68
Total Respondents: 354		

Q3 When you think about health challenges in the community where you live, what are you most concerned about? Choose up to 5

Answered: 354 Skipped: 0



Answer Choices	RESPONSES including Other responses	RESPONSES		
		26.27%		93
Access to healthcare services	50.2%	46.89%	178	166
Access to mental health services		31.07%		110
Cancer		24.01%		85
Chronic disease (diabetes, heart disease, high blood pressure, high cholesterol, stroke, etc.)	45.2%	44.92%	160	159
Falls		12.15%		43
Immunization rates		3.67%		13
Infectious disease (Hepatitis A, B or C, flu, etc.)	7.3%	5.93%	26	21
Intellectual or developmental disabilities		8.19%		29
Issues related to aging (arthritis, hearing/vision loss, etc.)	44%	43.50%	157	154
Lung disease (asthma, COPD, etc.)		7.91%		28
Overweight/obesity		45.20%		160
Physical activity	32%	31.07%	114	110
Prenatal care/maternal & infant health		11.30%		40
Sexually transmitted infections (including HIV)		3.95%		14
Substance abuse (drugs, alcohol, etc.)		60.17%		213
Suicide		10.73%		38
Tobacco use		18.08%		64
Other (please specify)		11.86%		42
Total Respondents: 354				

Q3. When you think about health challenges in the community where you live, what are you most concerned about? Choose up to 5.
42 total "Other" responses

- ◊ 2 excluded as equivalent to none.
- ◊ 25 interpreted to fall in one of the original options of answer choices & added to those counts as responses.
- ◊ 15 interpreted as not falling within an original answer choice & categorized by themes.

Access to Healthcare Services (12):

- Access to affordable health care/insurance
- COST of healthcare
- Barriers to accessing available services
- Having health care clinics (same day sick) in the communities, not 20 or more miles away.
- Your survey should have been done before the decision to have everything included with the UVM association. Many of us receive services to the south. The specialist we see were part of the clinics at Moses Ludington. We have had operations etc. done by them. We are being forced to accept ambulance services only to UVM associated facilities. Ticonderoga and the area community has lost its hospital and health services were considerably better and more available over 50 years ago. The move to the present system should have been discussed with all the community rather than giving the impression it was done behind closed doors. Horace Moses would "roll over in his grave" if he could see the present state of affairs regarding health care.
- Transportation to/from far off dr. Appts
- Transportation to health care facilities.
- Knowledge of available health care resources. Willingness to engage in health activities.
- Access to more family doctor
- Access to all services is a major barrier due to location
- home care aides and programs to keep people safely in their homes
- inadequate health insurance (high deductibles)

Chronic Diseases (1)

- Alzheimer's

Infectious Diseases (5)

- Lyme Disease: lack of Lyme-literate doctors/providers; Healthcare costs-100% out of pocket$!
- Lyme disease
- Lyme & West Nile
- Lyme disease and coinfections
- Health impacts of climate change, including Lyme disease and extreme weather

Issues Related to Aging (3)

- aging population
- Long term care for elderly needing housing/assistance
- complexity of obtaining/maintaining in-home care for the aging

Physical Activity (4):

- Access to a community based fitness/child/community center
- Physical inactivity
- Our Road systems and communities do not allow for active safe lifestyles - No shoulders, No (or poor) sidewalks, Unsafe speeds
- Access to activities for teens/children

OTHER (15)

Social Isolation/Lack of Community Connectivity (8):

- Social Isolation
- A sense of community, e.g., limited isolation; community members helping community members
- opportunities to socialize frequently and emphasis on exercise as a routine part of a day, ie integrated into lifestyle.
- Intolerance of diversity, e.g., LBGTQ, persons of color... limited cultural and ethnic diversity; lack of openness to change; lack of openness to liberal ideology Lack of economic opportunity and the way that that depresses the community as a whole. And, poorly educated people running the community services and their failure to acknowledge human dignity. Entrenched ideas that the people they serve are "less than".
- mental/emotional health of children, bullying, disrespect, anxiety of social settings
- Spiritual health
- effects of multi-generational poverty, family engagement issues with mental health and substance abuse services
- the high rate of violence, recently/fights, murder

Cost of Living/Wages/Housing (3):

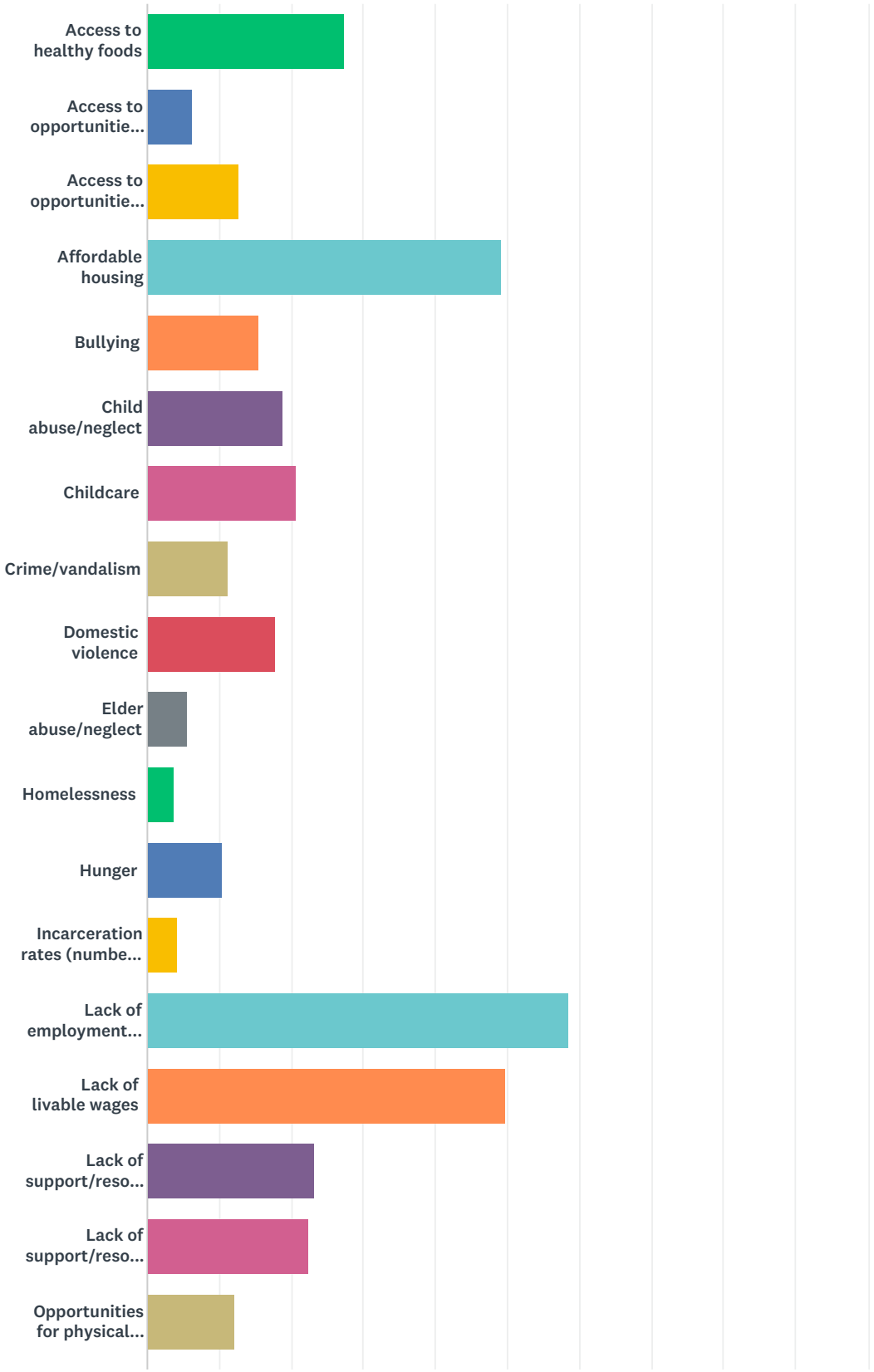
- Affordable cost of living - housing and wages
- Minimal livable wages combined with inadequate health insurance (high deductibles) lead to untreated physical conditions. Unhealthy working conditions lead to depressing and anxiety.
- Jobs and Affordable Living

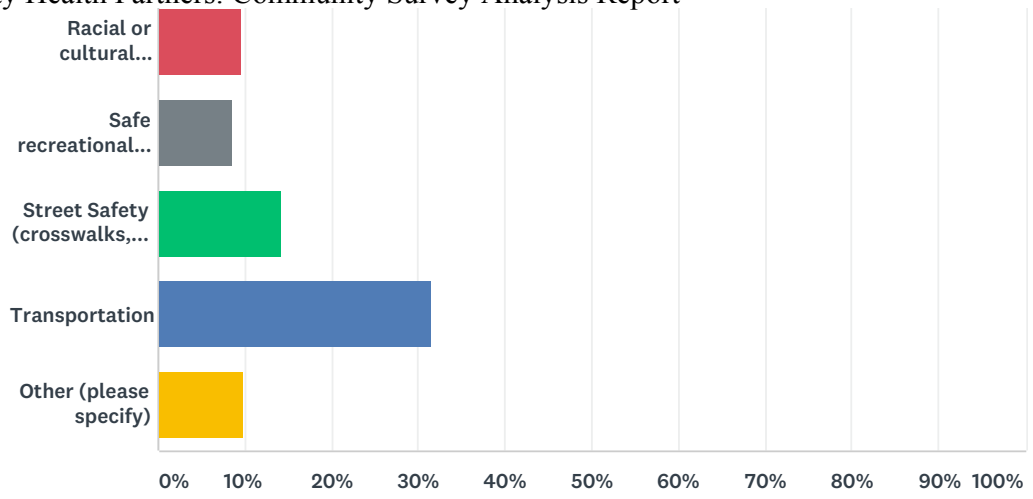
Miscellaneous (4):

- Environmental pollution from road salt and failing septic systems
- The utter Lack-Of food safety/hygiene exhibited by those in food service, ie-allowing pets into businesses where food is served, or servers without requisite hair nets/beard nets, and finding their locks in my food.!!!
- Health concerns of physical disabilities
- Health Director is unreachable and inapproachable

Q4 When you think about social challenges in the community where you live, what are you most concerned about? Choose up to 5

Answered: 354 Skipped: 0





ANSWER CHOICES	RESPONSES including Other responses	RESPONSES		
Access to healthy foods		27.40%		97
Access to opportunities for health for people with intellectual or developmental disabilities		6.21%		22
Access to opportunities for people with physical limitations or disabilities		12.71%		45
Affordable housing	49.4%	49.15%	175	174
Bullying	15.8%	15.54%	56	55
Child abuse/neglect		18.93%		67
Childcare	20.9%	20.62%	74	73
Crime/vandalism		11.30%		40
Domestic violence		17.80%		63
Elder abuse/neglect		5.65%		20
Homelessness		3.67%		13
Hunger		10.45%		37
Incarceration rates (number of people in jail)		4.24%		15
Lack of employment opportunities	58.75%	58.47%	208	207
Lack of livable wages	50%	49.72%	177	176
Lack of support/resources for seniors		23.16%		82
Lack of support/resources for youth		22.32%		79
Opportunities for physical activity	12.43%	12.15%	44	43
Racial or cultural discrimination		9.60%		34
Safe recreational areas	8.76%	8.47%	31	30
Street Safety (crosswalks, shoulders, bike lanes, traffic)		14.12%		50
Transportation		31.64%		112
Other (please specify)		9.89%		35
Total Respondents: 354				

Q4 When you think about social challenges in the community where you live, what are you most concerned about? Choose up to 5.

35 total "Other" responses

- ◊ 2 excluded as equivalent to none.
- ◊ 7 interpreted to fall in one of the original options of answer choices & added to those counts as responses.
- ◊ 26 interpreted as not falling within an original answer choice & categorized by themes.

Affordable Housing (1):

- safe and affordable housing

Bullying (1):

- The area is dysfunctional. There is a level of pettiness in everyday interactions and it comes from the top down. The whole area needs mass therapy. The bullies from childhood become the people in charge as adults and they're still bullies.

Childcare (1):

- Lack of community based center for overall health childcare and fitness

Lack of Employment Opportunities (1):

- Jobs with Benefits, like family health insurance, sick & vacation days, predictable hours, and a living/family wage

Lack of Livable Wages (1):

- Working poor struggle with transportation and affordable healthy food and housing

Opportunities for Physical Activity (1):

- Lack of community based center for overall health childcare and fitness

Safe Recreational Areas (1):

- no dog park or dog friendly places

OTHER (26)

Community Connectivity & Resources (8):

- Overall kindness and connectedness of the community
- resources need to be put out there. A lot of resources available, people don't know about
- Lack of knowledge of available resources.
- Lack of resources for middle class families
- Family Guidance
- Opportunities for cultural events with exchanges among people from different cultural ethnicities.
- "decent" broadband
- volunteer help for seniors

Substance Abuse/Mental Health (5):

- enabling of opioid abuse
- used needles found at the playground in park
- Impact of substance use; limited supportive housing for those in MH and SUD recovery
- peer pressure/socialization for vaping and/or drugs
- Stigma of mental health treatment

Healthcare Services (3):

- education and understanding of medical providers regarding testing & treatment for Lyme
- This survey should have been done a long time ago. Residents should be able to choose what health services will meet their needs.
- affordable health care

Animal Abuse/Control (3):

- Animal abuse
- animal abuse/cruelty
- lack of animal control and regulation

Housing Options (2):

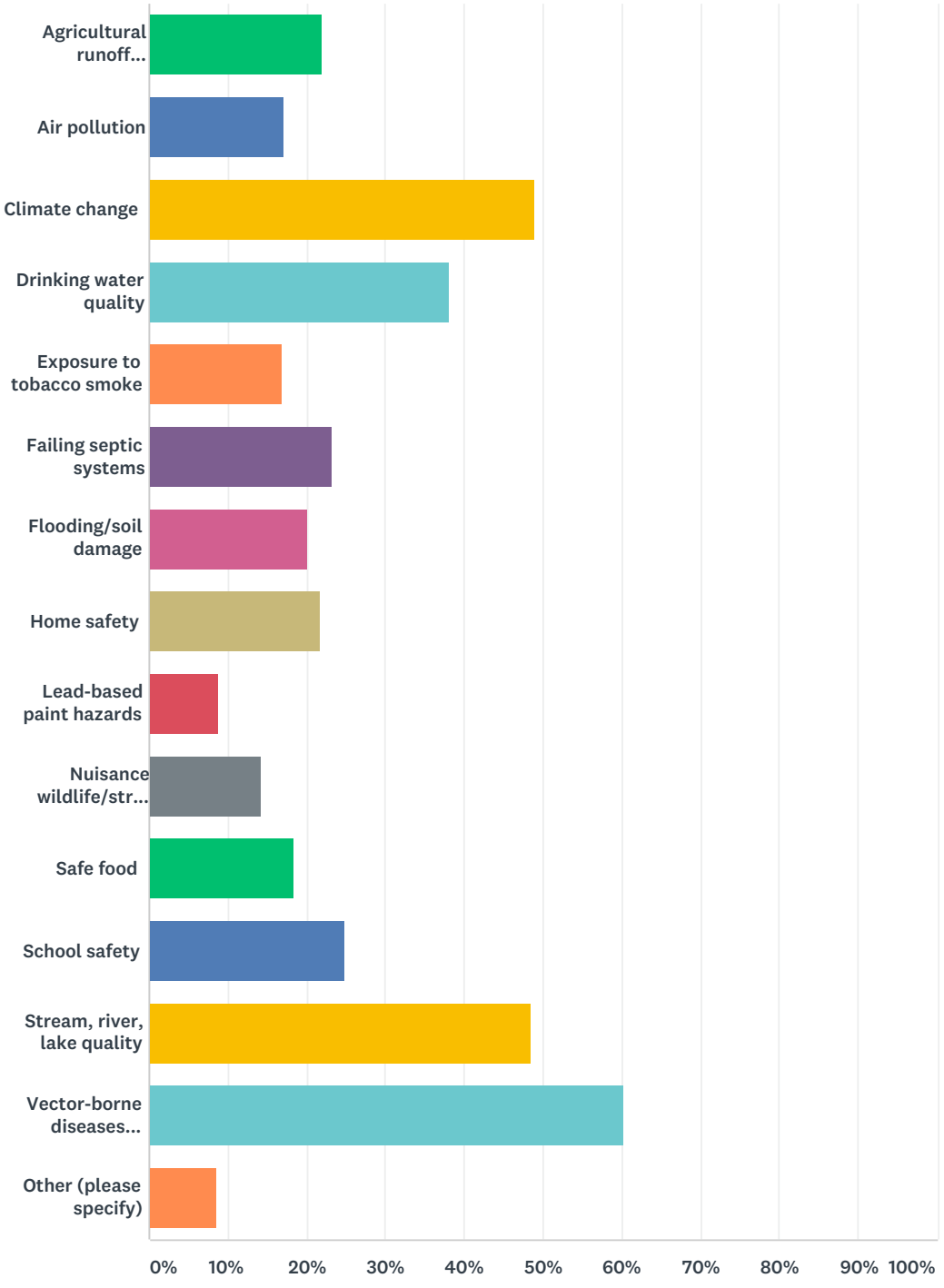
- small group living: non-institutional model
- There is no housing option for HEALTHY seniors

Miscellaneous Responses (5):

- Aging population and young people moving away. Good jobs can't be filled because we don't have the workforce.
- Impact of increased flooding on housing, economy, health, and more
- Increase in noise pollution with aftermarket truck tailpipes specifically designed to be louder and louder
- I don't think the education at the public school is preparing the next generation for the world we live in and they don't seem to be aware that they are falling very short.
- Essex County Health director is more concerned with her own political agenda than that of the community

Q5 When you think about environmental challenges in the community where you live, what are you most concerned about? Choose up to 5.

Answered: 354 Skipped: 0



ANSWER CHOICES	RESPONSES Other responses	RESPONSES	
Agricultural runoff (manure, pesticides, etc.)		22.03%	78
Air pollution	17.8%	17.23%	63 61
Climate change	49.2%	48.87%	174 173
Drinking water quality	38.4%	38.14%	136 135
Exposure to tobacco smoke		16.95%	60
Failing septic systems	23.7%	23.16%	84 82
Flooding/soil damage	20.3%	20.06%	72 71
Home safety		21.75%	77
Lead-based paint hazards		8.76%	31
Nuisance wildlife/stray animals		14.12%	50
Safe food		18.36%	65
School safety		24.86%	88
Stream, river, lake quality	49.4%	48.59%	175 172
Vector-borne diseases (mosquitoes, ticks, etc.)	60.7%	60.17%	215 213
Other (please specify)		8.47%	30
Total Respondents: 354			

Q5. When you think about environmental challenges in the community where you live, what are you most concerned about? Choose up to 5.

30 total "Other" responses (1 response included 2 topics)

- ◊ 2 excluded as equivalent to none.
- ◊ 12 interpreted to fall in one of the original options of answer choices & added to those counts as responses.
- ◊ 17 interpreted as not falling within an original answer choice & categorized by themes.

Air Pollution (2):

- Wood heat air pollution
- Increasing acid rain

Climate Change (1):

- CLIMATE CHANGE X10

Drinking Water (1):

- the alarm amount of cancer in Schroon and North Hudson, The level of iron is extremely high in the water tables in North Hudson. High levels of Iron in drinking water is known to cause prostate cancer in men. The water can not even be drank at the town fire house in North Hudson due to the run off from the old dump. DOH wont even let the Seniors have their picnic at fire house with out water being brought in. 4 people have had cancer that have lived with in a stones throw of the fire house. Two have passed, one is in remission and the other is fighting for his life. The Town of Schroon ...to many funerals of people that have died of cancer and the old timers sit at each funeral talking about the old dumping grounds for transformers in the sand pit right behind Tops. One man that lived right near that pit for years and then moved to NH recently passed from cancer. Someone needs to do testing on the pits and see if there is any trueth to the matter. They found it was true in a city north of us and Niagara Mohawk is doing a major clean up there.

Failing Septic Systems (2)

- Water treatment plant updates
- Failing municipal sewage treatment systems and discharges of untreated sewage to lakes and rivers

Flooding/Soil Damage (1):

- erosion around existing private bridges

Stream, River, Lake Quality (3):

- Spring contamination
- Lakefront property leaking waste into our water
- Storm water Runoff

Vector-borne Diseases (2)

- Lyme disease
- Rabies

OTHER (17)

Road Salt Contamination (4):

- road salt in waterways
- Road salt runoff
- Road salt contamination
- Road salt

Tourism Impacts (3):

- Tourist Impact on our Trails
- Overcrowding/Air B&Bs due to tourism
- Pedestrian safety towns and trailheads on Rt 73

Invasive Species (2):

- Invasive Species
- invasive species

Noise Pollution (2):

- noise pollution
- Wildly increasing noise pollution from aftermarket truck exhausts (which are illegal) and lack of enforcement. Constantly barking dogs at all hours.

Railway Oil Spill Risk (2):

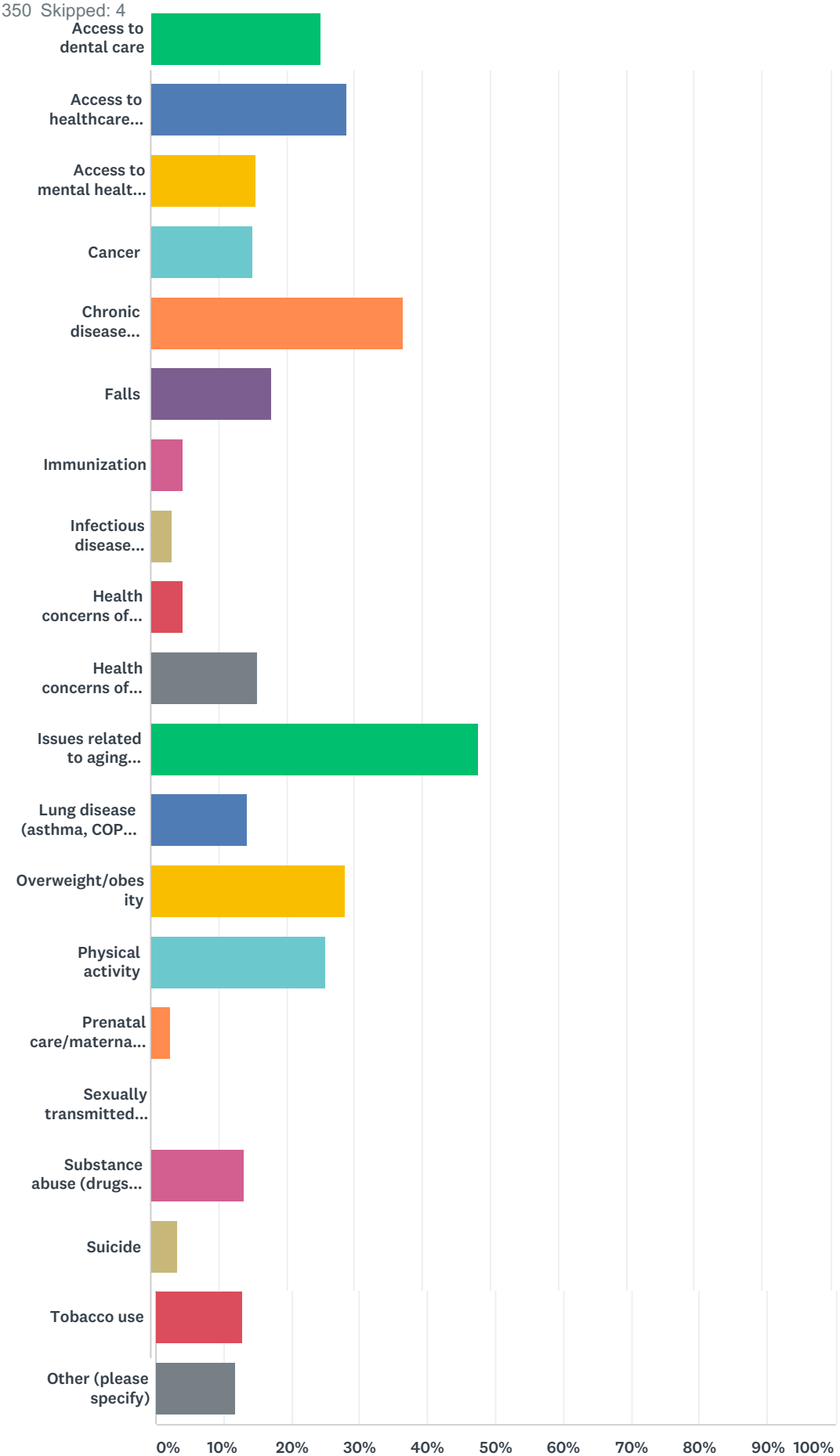
- Possibility of railroad spill of toxic materials
- "Oil Trains" passing through our area

Miscellaneous (4):

- Lack of complete and full recycling.
- Properly winterized homes
- Toxic waste, i guess something has to be causing high cancer rate.
- maintaining safe roadways in winter weather conditions

Q6 What health challenges have you or a family member had in the past year? Select all that apply

Answered: 350 Skipped: 4



ANSWER CHOICES	RESPONSES including Other responses	RESPONSES		
Access to dental care		25.14%		88
Access to healthcare services	33.4%	28.86%	117	101
Access to mental health services	15.7%	15.43%	55	54
Cancer		15.14%		53
Chronic disease (diabetes, heart disease, high blood pressure, high cholesterol, stroke, etc.)		37.14%		130
Falls		17.71%		62
Immunization		4.86%		17
Infectious disease (hepatitis A, B, C, flu, etc.)		3.14%		11
Health concerns of intellectual or developmental disability	6%	4.86%	21	17
Health concerns of physical disability		15.71%		55
Issues related to aging (arthritis, hearing/vision loss, etc.)		48.29%		169
Lung disease (asthma, COPD, etc.)		14.29%		50
Overweight/obesity		28.57%		100
Physical activity	26%	25.71%	91	90
Prenatal care/maternal & infant health		2.86%		10
Sexually transmitted infections (including HIV)		0.29%		1
Substance abuse (drugs, alcohol, etc.)		13.71%		48
Suicide		4.00%		14
Tobacco use		12.86%		45
Other (please specify)		11.71%		41
Total Respondents: 350				

Q6. What health challenges have you or a family member had in the past year? Select all that apply.

41 total "Other" responses

- ◊ 11 excluded as equivalent to none.
- ◊ 22 interpreted to fall in one of the original options of answer choices & added to those counts as responses.
- ◊ 8 interpreted as not falling within an original answer choice & categorized by themes.

Healthcare Access (16):

- Insurance/Affordability Related:
  - Insurance Coverage
  - Family Group Health Coverage
  - Affordable health care
  - ..used to be health insurance, finally got it thru work, only took 14 year...still don't get it tho when I am laid off...it costs 689 dollars for one month of COBRA.
  - Affordable health services
  - paying for medication
  - Access to government aid
  - High cost of health and dental care
- Care Related:
  - Problems with bad surgery event
  - Medical errors
  - Gynecology concerns
- Location/Travel/Time Related:
  - We recently moved to Essex County from NYC. I needed to see a medical specialist urgently and could Norbert get an appointment within 2 months (in Essex County). So, called my NYC providers and had an appointment scheduled within a week. So drove 5 plus hours one way or medical provider
  - The amount of specialty in the area
  - Waiting 5 months for a specialist appointment-gastro. Too long!
- Respite for Alzheimer's caregivers
- Excellent, local health care, knowledgeable and caring Drs. and PAs

Access to mental health services (1):

- Access the "right kind" of mental health care, the area needs a residential behavioral therapy center and respite care that can be accessed without waiting lists or piles of paperwork or bring in full blown crisis.

Infectious Disease (4):

- Lyme Disease
- Lyme disease
- Lyme Disease
- lyme disease

Physical Activity (1):

- Lack of access to high school buildings for exercise/walking

OTHER (8)

Childcare (2):

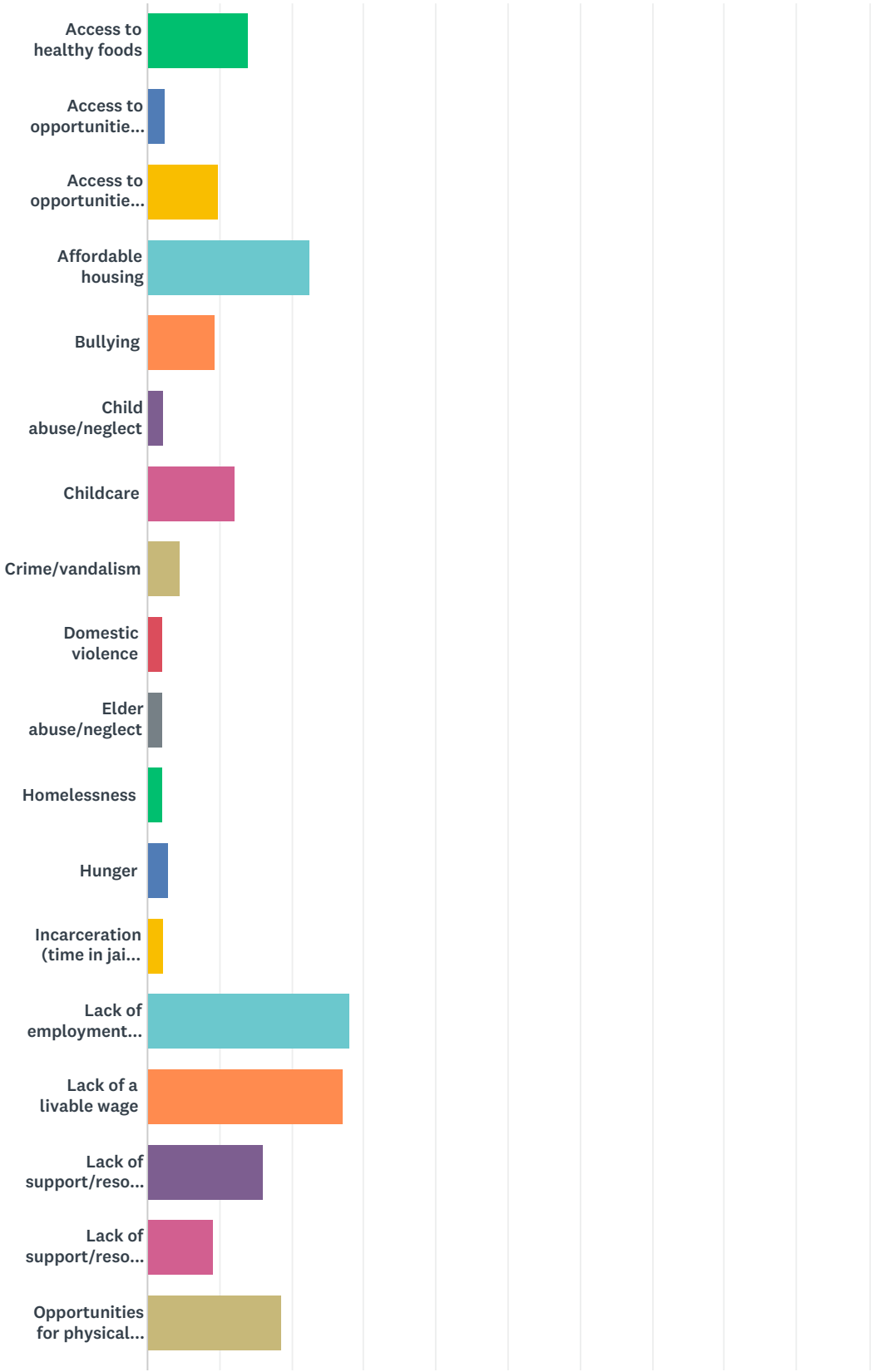
- Community based childcare center
- No child care

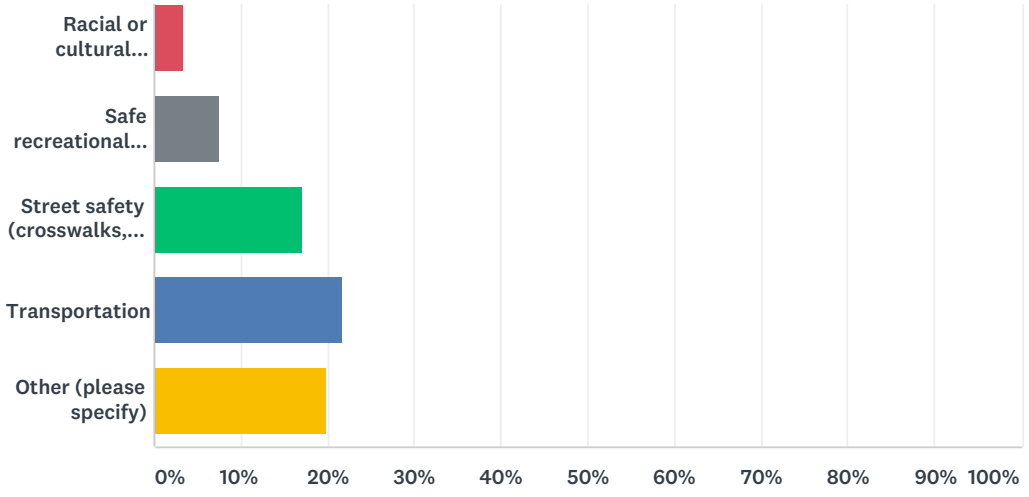
Miscellaneous (6):

- There are not enough services more local for senior citizens who aren't exactly home bound but aren't independent. There should be community vans or other means of transportation for the elderly whom aren't driving. They could still get around and have a better quality of life.
- Driving to simply go for a walk due to unsafe neighborhoods (again, shoulders, lighting and speeds)
- Again, my mental state and sense of happiness has been impacted by the increasing noise pollution, and lack of animal control/regulation in Elizabethtown, animals particularly in the Water St/Noble Terrace area.
- Anxiety
- Health Director does not understand community which she is to represent and only represents her fellow political associates. Citizens are left with no outreach or ability to obtain assistance from her department
- Very fortunate this year

Q7 What social challenges have you or a family member had in the past year? Select all that apply.

Answered: 349 Skipped: 5





ANSWER CHOICES	RESPONSES including Other responses	RESPONSES		
Access to healthy foods	14.3%	14.04%	50	49
Access to opportunities for health for those with intellectual or developmental disabilities		2.58%		9
Access to opportunities for health for those with physical limitations or disabilities		9.74%		34
Affordable housing	23%	22.64%	80	79
Bullying		9.46%		33
Child abuse/neglect		2.29%		8
Childcare		12.03%		42
Crime/vandalism		4.58%		16
Domestic violence		2.01%		7
Elder abuse/neglect		2.01%		7
Homelessness		2.01%		7
Hunger		2.87%		10
Incarceration (time in jail or prison)		2.29%		8
Lack of employment opportunities		28.08%		98
Lack of a livable wage		27.22%		95
Lack of support/resources for seniors		16.05%		56
Lack of support/resources for youth	9.5%	9.17%	33	32
Opportunities for physical activity		18.62%		65
Racial or cultural discrimination		3.44%		12
Safe recreational areas		7.45%		26
Street safety (crosswalks, shoulders, bike lanes, traffic, etc.)		17.19%		60
Transportation		21.78%		76
Other (please specify)		19.77%		69
Total Respondents: 349				

Q7. What social challenges have you or a family member had in the past year? Select all that apply.

69 total "Other" responses (1 answer included under 2 responses)

- ◊ 56 excluded as equivalent to none.
- ◊ 3 interpreted to fall in one of the original options of answer choices & added to those counts as responses.
- ◊ 11 interpreted as not falling within an original answer choice & categorized by themes.

Access to healthy foods (1):

- lack of access to affordable food, utilities, household items

Affordable Housing (1):

- lack of access to affordable food, utilities, household items

Lack of Support/Resources for Youth (1):

- Lack or the "right kind" of support for youth. Mental health support that doesn't come with strings attached or a home invasion by every department in the county

<u>OTHER (11)</u>

Isolation or Lack of Community Connectivity (4):

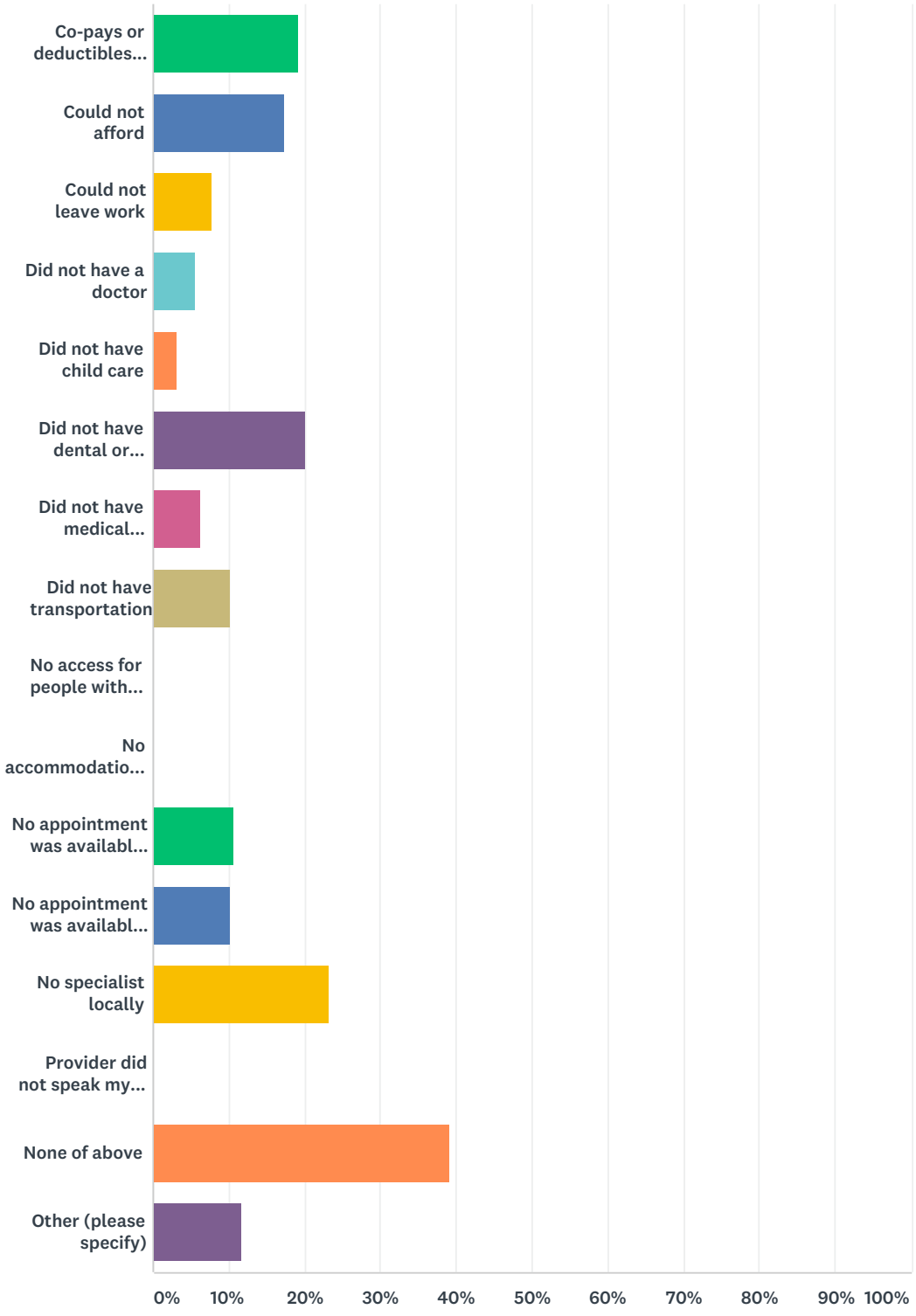
- Opportunities for social interaction
- I don't tell a soul that I happen to be gay...because of where I live, and where I work. Pretty sad...
- lack of diversity in the neighborhood
- Harassment via social media

Miscellaneous (7):

- Lyme disease
- Access to government aid
- Many of these problems for others
- Fortunately all our needs were met
- We have enough money to meet our needs personally
- Limited access to forest areas recently acquired by the state for seniors
- Twin 21 yr olds junkies or politically correct term addicted to opiates

Q8 If there was a time in the past year that you or a family member needed medical care but could not get it, why did you not get care? Select all that apply.

Answered: 353 Skipped: 1



ANSWER CHOICES	RESPONSES including Other responses	RESPONSES	
Co-pays or deductibles were too high		19.26%	68
Could not afford	17.8%	17.28%	63 61
Could not leave work		7.65%	27
Did not have a doctor		5.67%	20
Did not have child care		3.12%	11
Did not have dental or vision insurance	20.7%	20.11%	73 71
Did not have medical insurance		6.23%	22
Did not have transportation		10.20%	36
No access for people with physical disabilities		0.28%	1
No accommodations for people with intellectual or developmental disabilities		0.28%	1
No appointment was available (primary care)	11%	10.76%	38
No appointment was available (specialist)		10.20%	39 36
No specialist locally	23.8%	23.23%	84 82
Provider did not speak my language		0.28%	1
None of above		39.09%	138
Other (please specify)		11.61%	41
Total Respondents: 353			

Q8 If there was a time in the past year that you or a family member needed medical care but could not get it, why did you not get care? Select all that apply.

41 total "Other" responses

- ◊ 17 excluded as equivalent to none.
- ◊ 11 interpreted to fall in one of the original options of answer choices & added to those counts as responses.
- ◊ 13 interpreted as not falling within an original answer choice & categorized by themes

Could not afford (2):

- Medicare Part D too expensive
- Health insurance is not affordable. Physicians do not listen to concerns of their patients. Not addressing pain adequately by providers negatively impacts the patient & their family.

Did not have dental or vision insurance (2):

- Dental ins is expensive and dental work is expensive
- no insurance for dental care for elderly and pays out of pocket

No appointment was available (specialist) (3):

- We moved here 2+ years ago, and still have to travel 30-40 miles to see a dermatologist, rheumatologist, and the cardiologist.
- Could not get a referral to a specialist until I was very ill then had to wait 3 more months
- waiting 5 months for specialist appt

No specialist locally (4):

- Had to travel over an hour to see a doctor
- Most of our medical care is done in Vermont, which is a 4+ hour round trip
- Travel to quality medical care is too far
- availability of in network providers in the area

OTHER (13)

Location/Travel Availability of Providers/Services (7):

- radiation in plattsburgh, not really local. just want to say i have learned about resources are there just need to be aware.
- Unable to find a clinic for same-day sick appointment without having to drive 35 or more miles, which I was too sick to do.

Lyme Disease (2):

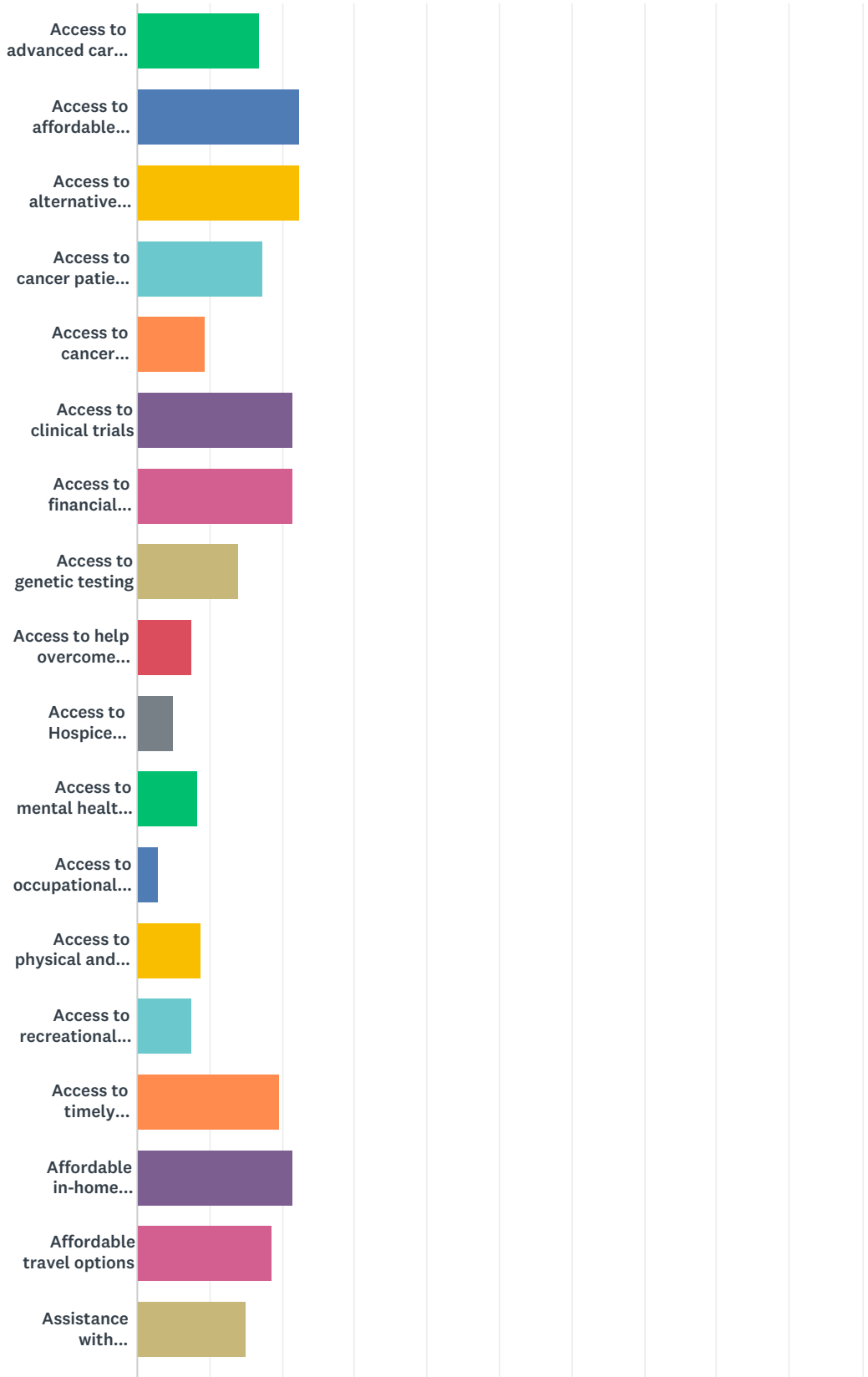
- Lyme Disease errors in testing; cost out of pocket for treatment
- Lyme disease

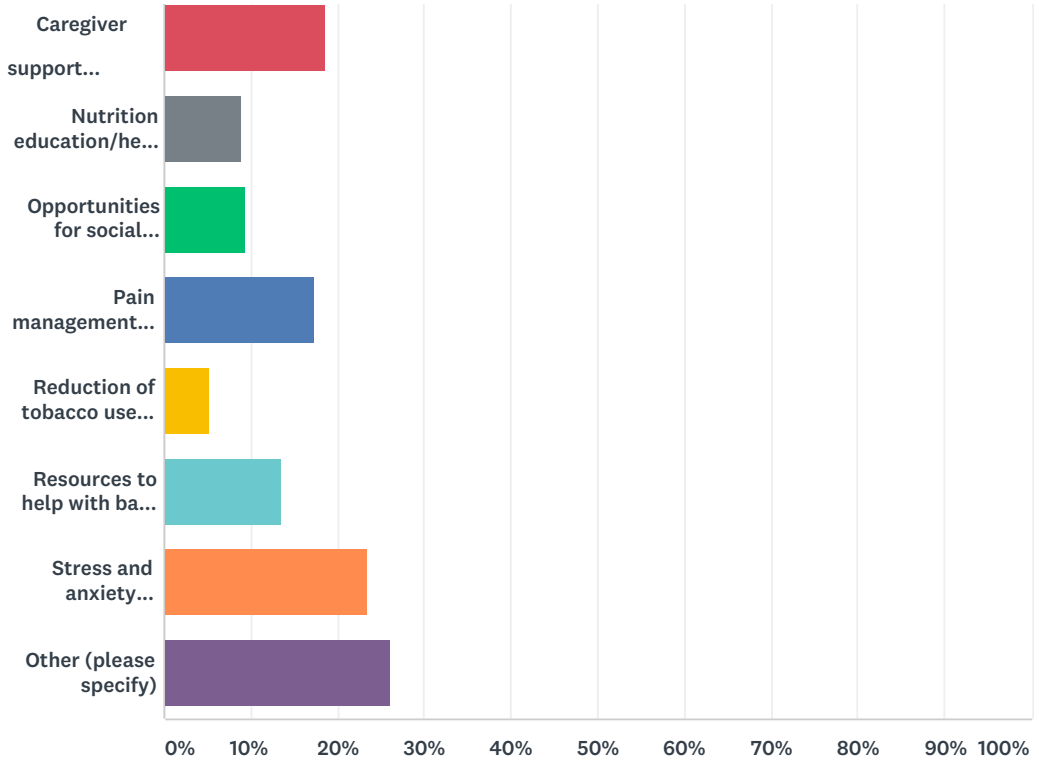
Miscellaneous (4):

- The specialist was not willing to listen to my concerns and did not help me in any way.
- Appointment took place but specialist only saw me for <5 minutes
- mental health services
- I am a VA patient
- we have sought medical care and often paid out of pocket for it

Q9 Select the cancer services you feel are missing or lacking in the community based on your experience. Select all that apply.

Answered: 264 Skipped: 90





ANSWER CHOICES	RESPONSES including Other responses	RESPONSES	
Access to advanced care planning		17.05%	45
Access to affordable prescription/medication coverage		22.35%	59
Access to alternative healthcare providers (acupuncture, chiropractors, etc.)		22.35%	59
Access to cancer patient support groups		17.42%	46
Access to cancer screenings/resources/information		9.47%	25
Access to clinical trials		21.59%	57
Access to financial assistance programs for co-pays and bills		21.59%	57
Access to genetic testing		14.02%	37
Access to help overcome drug/alcohol dependence		7.58%	20
Access to Hospice services		4.92%	13
Access to mental health services		8.33%	22
Access to occupational therapy		3.03%	8
Access to physical and exercise therapy		8.71%	23
Access to recreational/exercise facilities and services for individuals with physical impairments and disabilities		7.58%	20
Access to timely specialty care		19.70%	52
Affordable in-home services	22%	21.59%	58 57
Affordable travel options		18.56%	49
Assistance with understanding health insurance benefits and coverage		15.15%	40

Caregiver support (respite)		18.56%		49
Nutrition education/healthy meal planning		9.09%		24
Opportunities for social connections		9.47%		25
Pain management services	18%	17.42%	48	46
Reduction of tobacco use including e-cigarettes		5.30%		14
Resources to help with basic needs (food, housing, paying bills, etc.)		13.64%		36
Stress and anxiety resources and treatment		23.48%		62
Other (please specify)		26.14%		69
Total Respondents: 264				

Q9. **Select the cancer services you feel are missing or lacking in the community based on your experience. Select all that apply.**

69 total "Other" responses

- ◊ 49 excluded as equivalent to none.
- ◊ 3 interpreted to fall in one of the original options of answer choices & added to those counts as responses.
- ◊ 17 interpreted as not falling within an original answer choice & categorized by themes

Affordable in-home services (1):

- Access to information about support services for persons able to pay out of pocket for those services. It's difficult to get in-home and other services if you are not on Medicaid or Medicare (and even then, it's not necessarily easy).

Pain Management Services (2):

- pain management without opioids! cannabis; food prep/menu counseling
- Access to pain management

OTHER (17)

Travel/Distance (4):

- Driving to Burlington and/or Plattsburgh at times daily for radiation/chemo was expensive and exhausting
- There are no cancer services in my community
- Need to travel for state of the art care
- How to drive a hundred miles a day to get radiation and a hundred miles every two weeks for chemo treatment

Miscellaneous (9):

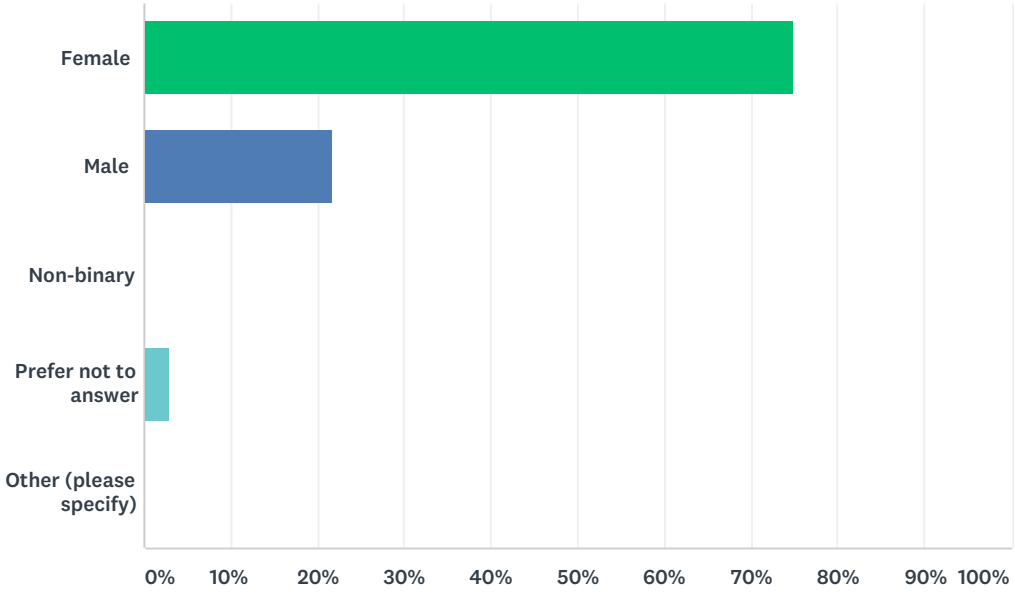
- I have only had small skin cancers, which were removed by the doctor
- My husband had cancer, but he handled his problems himself.
- This is tough for me, I lived and learned. Again, there are resources but you just go, listen and learn. I went to CVPH and had help with most of the above, also "John" at OFA was a big help.
- Don't know much about services

Miscellaneous positive experiences (4):

- We had good experiences
- I feel that we are doing really well with resources and I am happy with the help and support my grandparents had and that my aunt is getting now.
- I was diagnosed with colon cancer and had an operation to remove part of my colon. I have been very fortunate so far and have not had need of many of the services mentioned. I could imagine affordable home services being a real challenge.
- 2007...just happened to have gotten health ins just before I got diagnosed with Melanoma. Had Interferon every single day for a month, then 3 times a week for a whole year in Plattsburgh. Then 10 years of bi-yearly checkups at Fletcher Alan (to see the surgeon), and in P'burgh

Q10 What gender do you identify with?

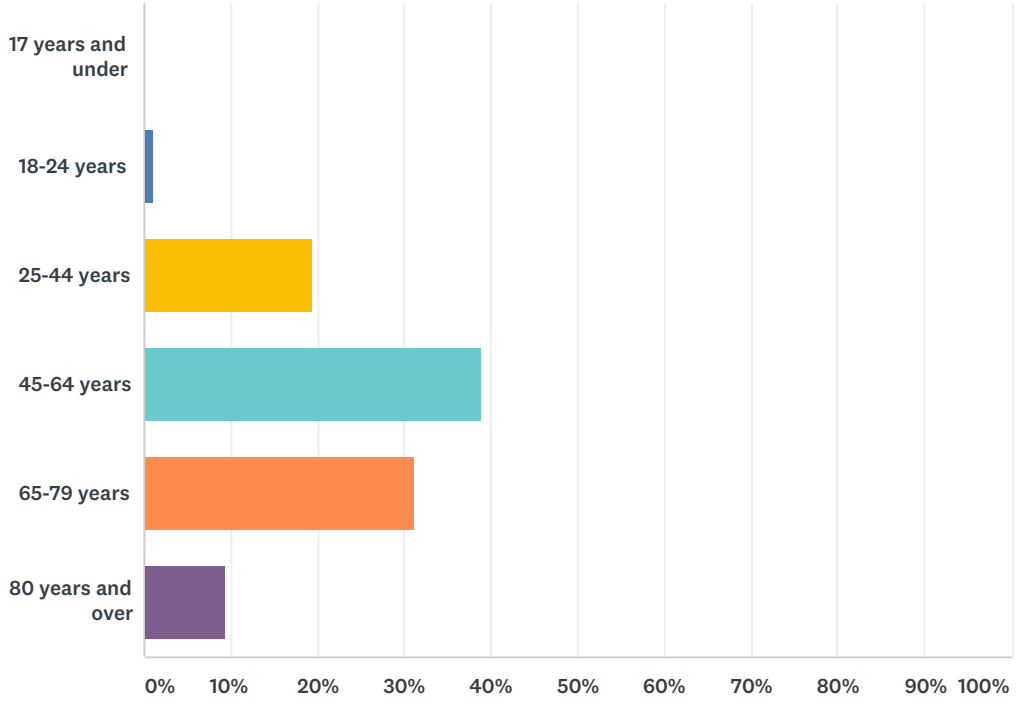
Answered: 354 Skipped: 0



ANSWER CHOICES	RESPONSES	
Female	74.86%	265
Male	21.75%	77
Non-binary	0.28%	1
Prefer not to answer	2.82%	10
Other (please specify)	0.28%	1
TOTAL		354

Q11 What is your age?

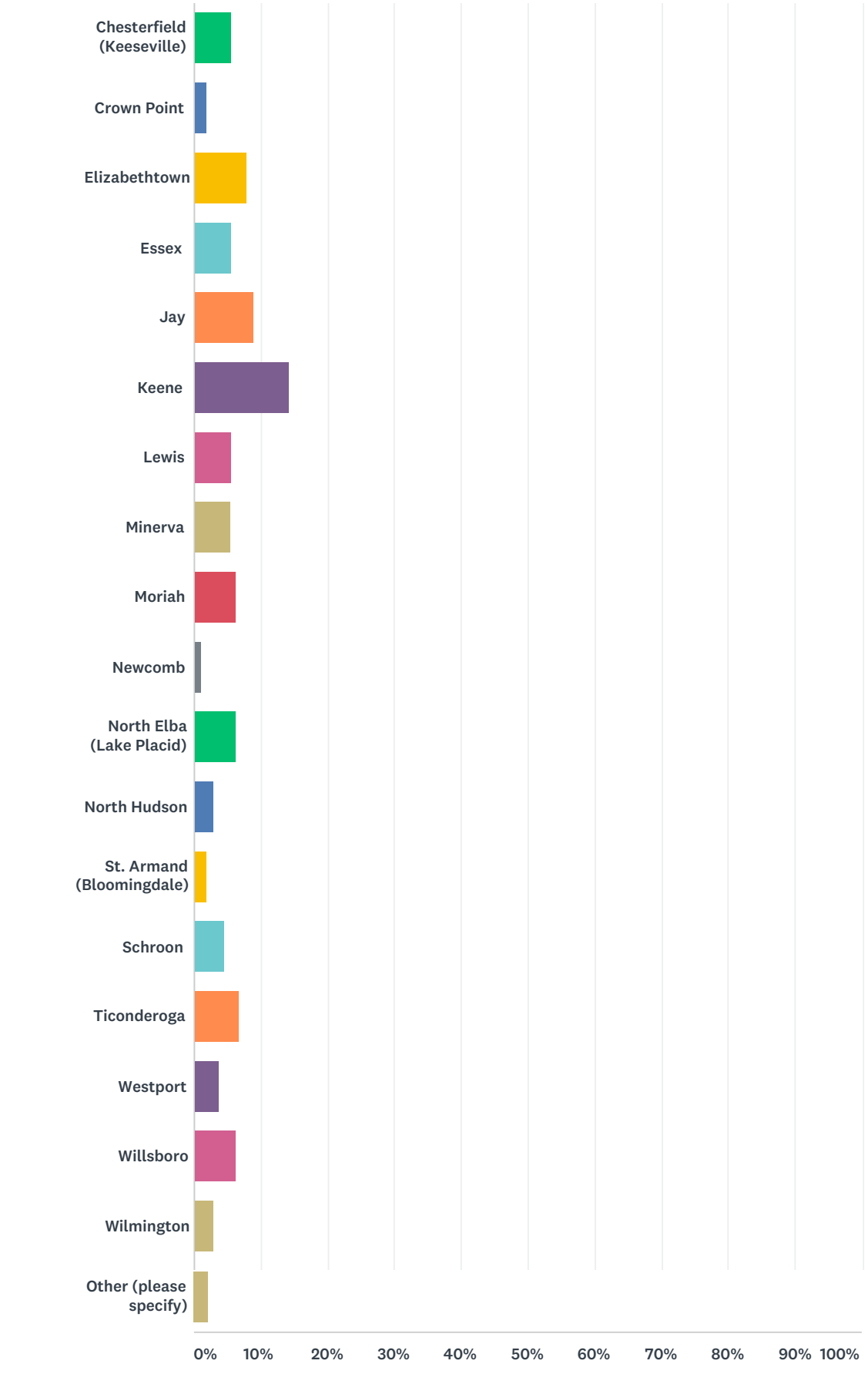
Answered: 354 Skipped: 0



ANSWER CHOICES	RESPONSES	
17 years and under	0.00%	0
18-24 years	1.13%	4
25-44 years	19.49%	69
45-64 years	38.98%	138
65-79 years	31.07%	110
80 years and over	9.32%	33
TOTAL		354

Q12 What city/town do you live in? Select only one based on your primary residence.

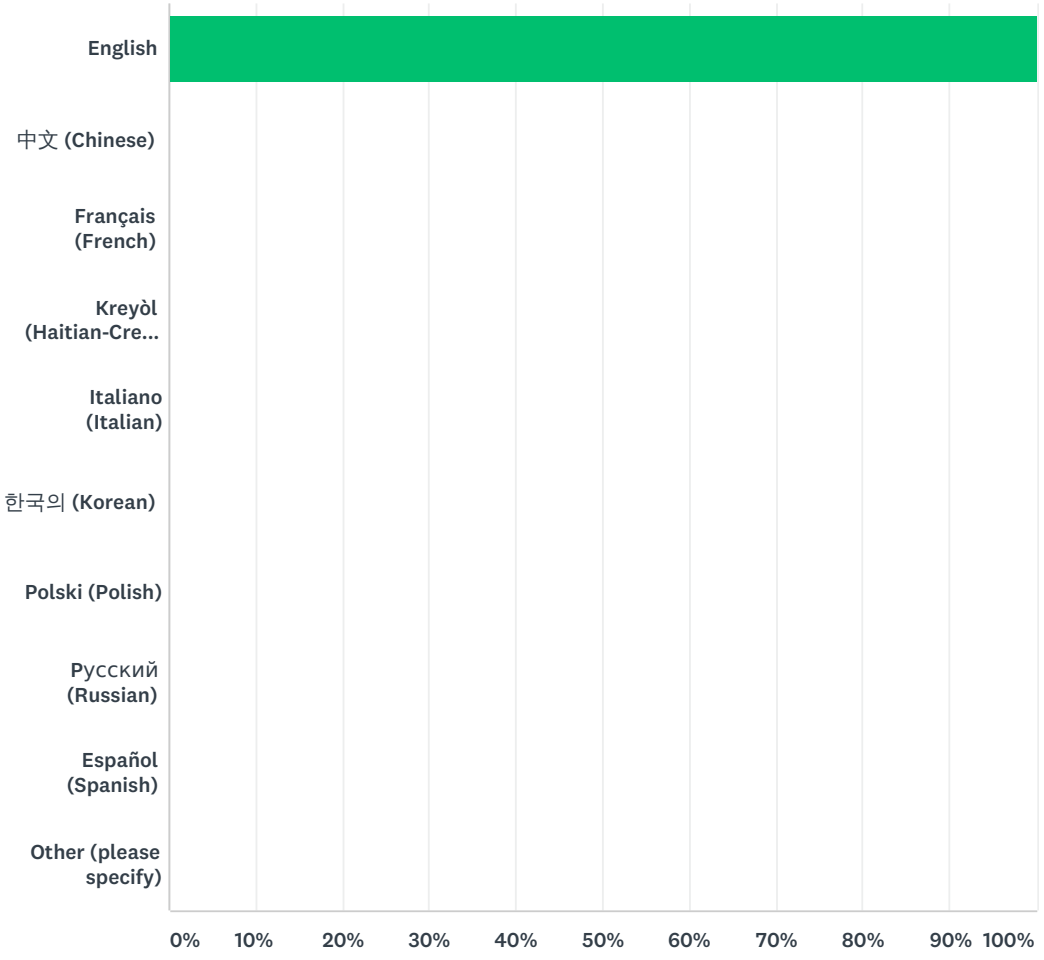
Answered: 354 Skipped: 0



ANSWER CHOICES	RESPONSES	
Chesterfield (Keeseville)	5.65%	20
Crown Point	1.98%	7
Elizabethtown	7.91%	28
Essex	5.65%	20
Jay	9.04%	32
Keene	14.12%	50
Lewis	5.65%	20
Minerva	5.37%	19
Moriah	6.21%	22
Newcomb	1.13%	4
North Elba (Lake Placid)	6.21%	22
North Hudson	2.82%	10
St. Armand (Bloomingdale)	1.98%	7
Schroon	4.52%	16
Ticonderoga	6.78%	24
Westport	3.67%	13
Willsboro	6.21%	22
Wilmington	2.82%	10
Other (please specify)	2.26%	8
TOTAL		354

Q13 What is the primary language spoken in your household?

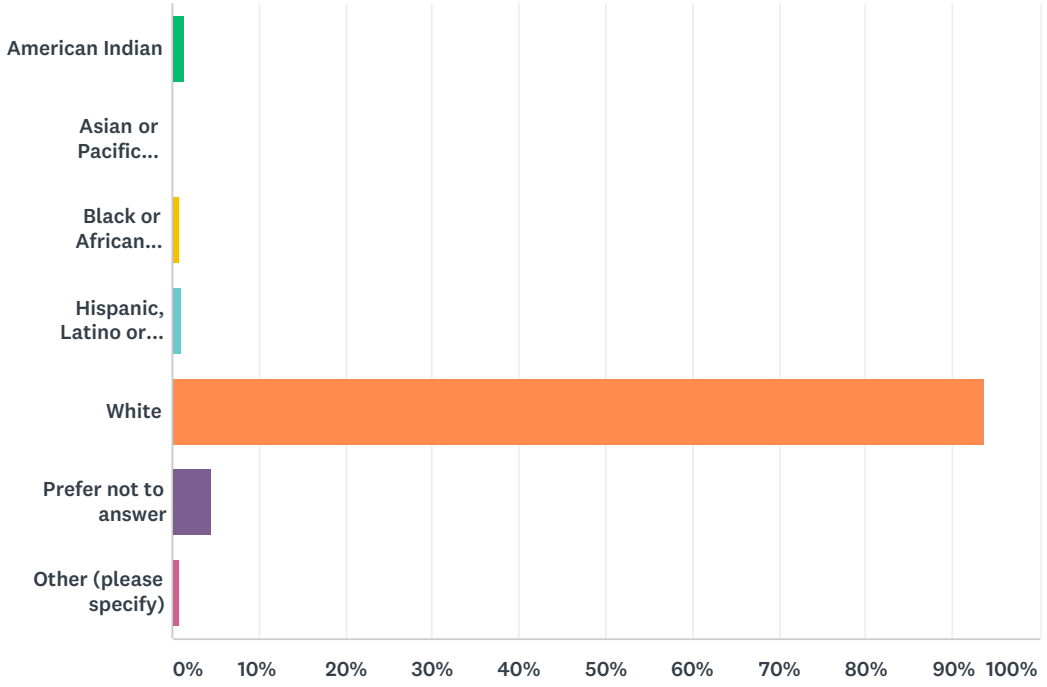
Answered: 354 Skipped: 0



ANSWER CHOICES	RESPONSES	
English	100.00%	354
中文 (Chinese)	0.00%	0
Français (French)	0.00%	0
Kreyòl (Haitian-Creole)	0.00%	0
Italiano (Italian)	0.00%	0
한국의 (Korean)	0.00%	0
Polski (Polish)	0.00%	0
Русский (Russian)	0.00%	0
Español (Spanish)	0.00%	0
Other (please specify)	0.00%	0
TOTAL		354

Q14 What is your race/ethnicity? Select all that apply.

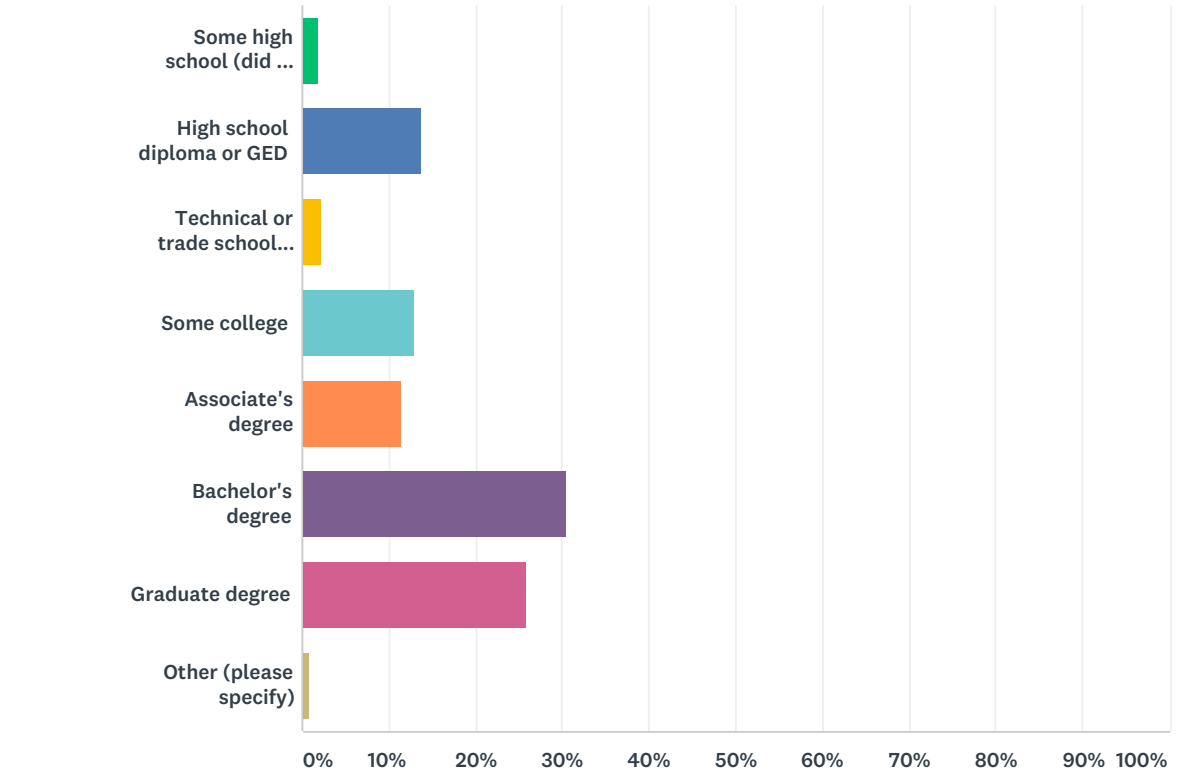
Answered: 354 Skipped: 0



ANSWER CHOICES	RESPONSES	
American Indian	1.41%	5
Asian or Pacific Islander	0.28%	1
Black or African American	0.85%	3
Hispanic, Latino or Spanish origin	1.13%	4
White	93.79%	332
Prefer not to answer	4.52%	16
Other (please specify)	0.85%	3
Total Respondents: 354		

Q15 What is your highest level of education?

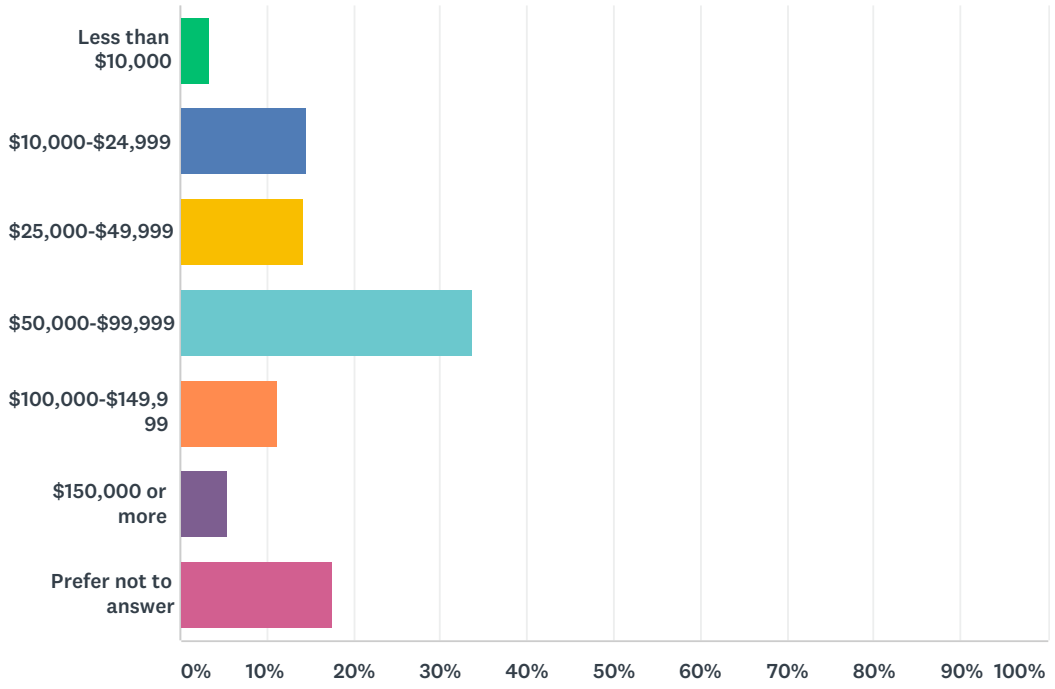
Answered: 354 Skipped: 0



ANSWER CHOICES	RESPONSES	
Some high school (did not finish)	1.98%	7
High school diploma or GED	13.84%	49
Technical or trade school certificate	2.26%	8
Some college	12.99%	46
Associate's degree	11.58%	41
Bachelor's degree	30.51%	108
Graduate degree	25.99%	92
Other (please specify)	0.85%	3
TOTAL		354

Q16 What is your household's annual income?

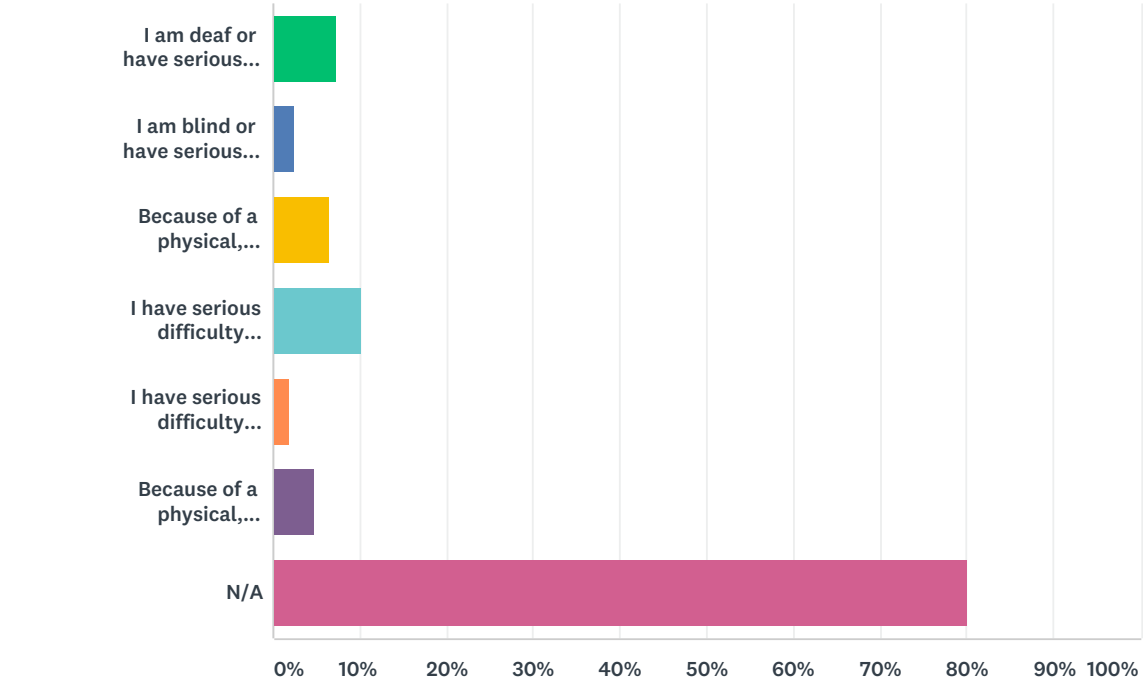
Answered: 354 Skipped: 0



ANSWER CHOICES	RESPONSES	
Less than $10,000	3.39%	12
$10,000-$24,999	14.69%	52
$25,000-$49,999	14.12%	50
$50,000-$99,999	33.62%	119
$100,000-$149,999	11.30%	40
$150,000 or more	5.37%	19
Prefer not to answer	17.51%	62
TOTAL		354

Q17 Do any of the following apply to you? Select all that apply.

Answered: 354 Skipped: 0



ANSWER CHOICES	RESPONSES	
I am deaf or have serious difficulty hearing	7.34%	26
I am blind or have serious difficulty seeing, even when wearing glasses	2.54%	9
Because of a physical, mental, or emotional condition, I have serious difficulty concentrating, remembering, or making decisions.	6.50%	23
I have serious difficulty walking or climbing stairs	10.17%	36
I have serious difficulty dressing or bathing	1.98%	7
Because of a physical, mental, or emotional condition, I have difficulty doing errands alone, such as visiting a doctor's office or shopping.	4.80%	17
N/A	80.23%	284
Total Respondents: 354		

Appendix 7:

Stakeholder Survey Analysis Report

May 2019

Report

Purpose

The purpose of the Stakeholder Survey was to gain valuable insight from key informants into the factors that are impacting the health and well-being of the people their organization/agency serves.

Responses are to be integrated as part of the qualitative data that informs the comprehensive Essex County Community Health Assessment (CHA) along with additional qualitative and quantitative data.

Design

The survey was developed by the Data Subcommittee of the Community Health Assessment Committee; a 7-county regional committee facilitated by the Adirondack Rural Health Network (ARHN), a program of the Adirondack Health Institute (AHI). The survey was launched electronically on the Survey Monkey platform; a paper version was not available. The average expected completion time was 20 minutes for 20 questions or data entries in sections:

- Q 1-6: Organization/Agency/Service Area
- Q 7: Rankling of Prevention Agenda Priority Areas
- Q 7-9: Health Priorities, Concerns & Factors
- Q 10-11: Social Determinants of Health
- Q 12- 14: Improving Health & Well-Being
- Q 15: Additional Comments/Recommendations

Distribution and Participation

The target population of the survey was key informants from a wide cross section of 18 different community based organization types. Essex County Health Partners used internal contact lists based on existing lists of committees, coalitions, networks, partnerships and contacts to identify key informants. Organizations that serve multiple counties or the region were primarily identified by the county in which the organization has a physical facility though they could select which counties they served within the survey.

ARHN maintained a comprehensive list in Excel format with a tab for each county. There were 170 targeted individuals in the Essex County tab of this file. The Essex County Director of Public Health sent an email invitation including an introduction and link to the survey to all of these individuals in January 2019. ARHN used the excel file to track responses from targeted stakeholders and report back out to partners on progress and for partners to re-invite stakeholders.

Analysis Process

ARHN provided a regional report entitled Summary of 2019 Community Stakeholder Survey, included at the end of this report, and an Excel document of downloaded Survey Monkey responses specific to Essex County. Both of these documents were used to examine Essex County data and create this report specific to Essex County.

Responses

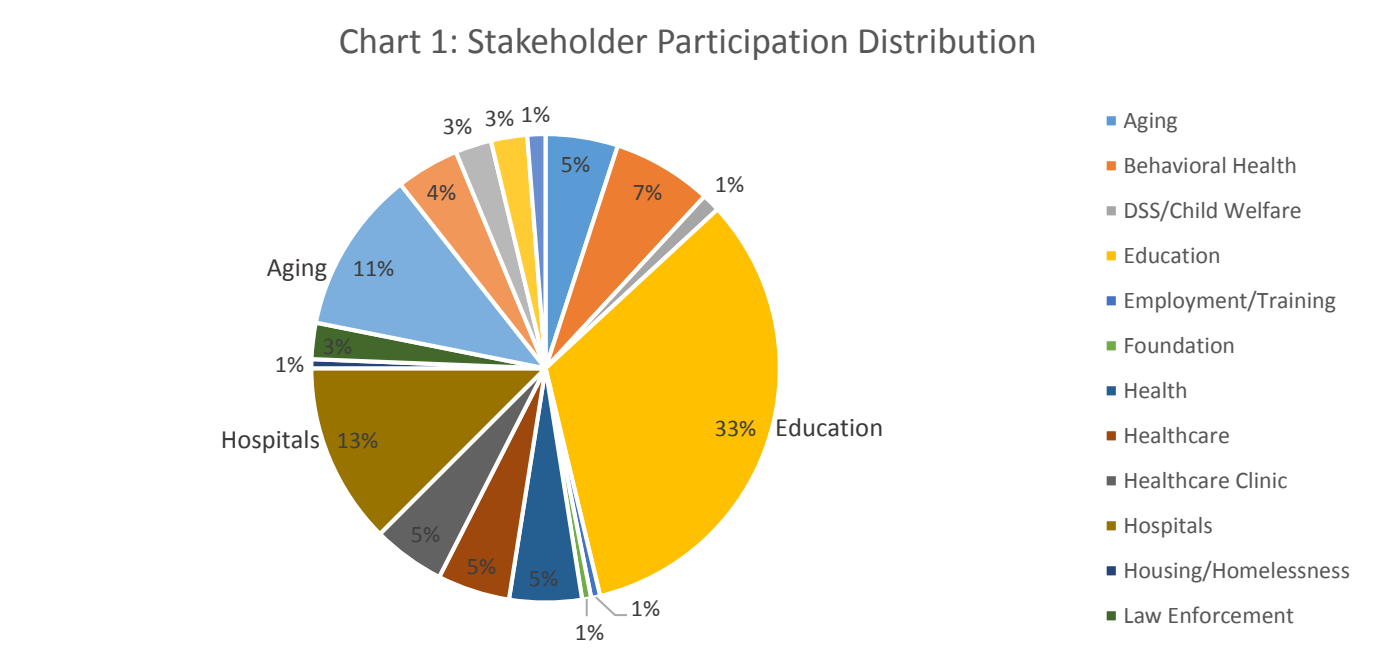
170 Targeted individuals

Collected and included in the responses as summarized by Adirondack Rural Health Network:

- **129 responses total**
- 39 responses from the target list
- 90 responses from others outside the targeted stakeholder list. Most responses were from
  - people within organizations that serve the region - hospitals, pediatrician practices, nursing homes, behavioral/drug services, employment placing, etc. that another county identified but serves Essex County and
  - people within organizations that were targeted (expected due to link having been shared with others within the target organization leading to 1 or 2 people participants from an identified organization).
- Other notable inclusions in the results for Essex County were:
  - 4 responses from a single targeted agency (including the originally targeted individual)
  - 21 from another targeted agency (including the originally targeted individual).
  - 3 people participated in the survey twice.
  - 2 participants from Clinton County government or a Town in Clinton County that selected Essex County as a service area.

Stakeholder Groups

There were 18 groups/categories of stakeholders identified by Essex County Health Partners invited to take the survey. Chart 1 demonstrates the participation distribution across these categories. Notably, the largest percentages of responses were from Education, Hospitals & organizations that serve our Aging population.



Approximately 43% of responses were from the Administrator/Director level; approximately 23% Direct Service Staff followed by other categories of Manager (10% and others 24%) (Question 3 in the survey).

Regional responses demonstrated the greatest number of participants from community sectors of School (K-12) (69; including 21 from a single organization and 4 from another); Healthcare Provider (53); Social Services (50). All other sectors demonstrated under 40 responses (Question 5 in the survey).

Major Findings

Concerns, Contributing Factors and Social Determinants of Health

Participants most frequently identified the **top 5 health concerns** [from a list of 43 plus an Other option] (Question 8), as:

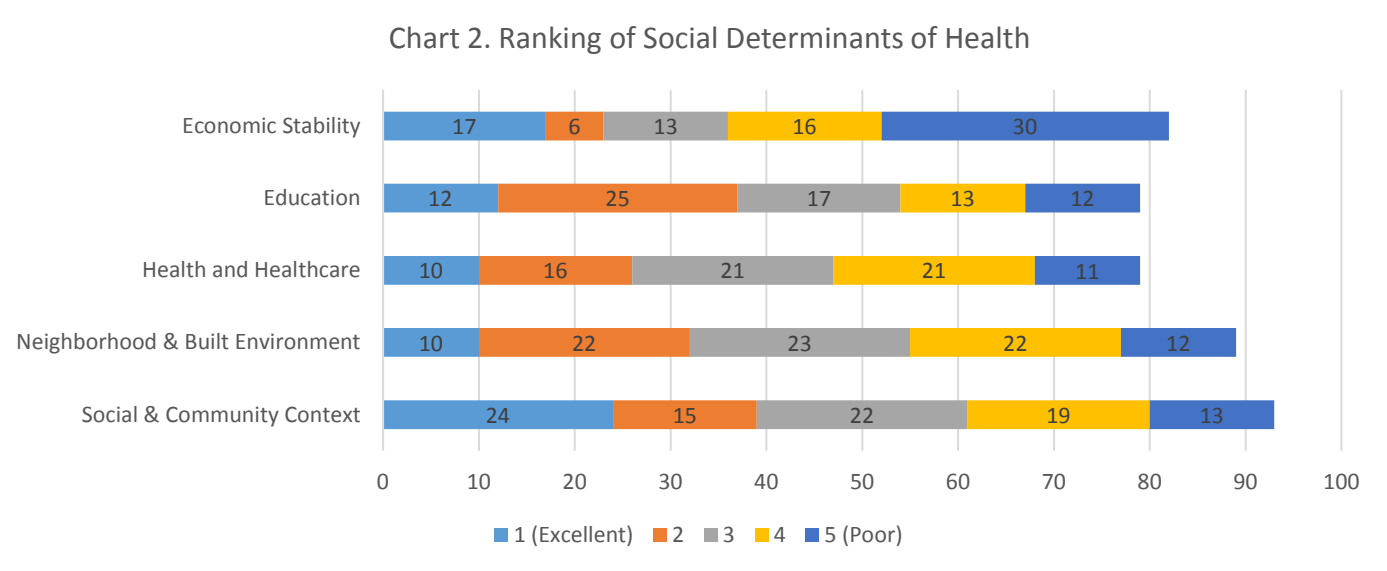
1. Substance Abuse,
2. Mental Health Concerns,
3. Child/Adolescent Emotional Health,
4. Overweight/Obesity and
5. Adverse Childhood Experiences.

Participants most frequently identified the **top 5 contributing factors** [from a list of 50 plus an Other option] (Question 9), as:

1. Poverty,
2. Lack of Mental Health Services,
3. Changing Family Structures,
4. Addiction to Illicit Drugs and
5. Age of Residents.

Participants were provided an explanation of **Social determinants of health** and asked to rank them in order of 1-5 believed to be impacting residents on a scale of (1) "excellent" to (5)"very poor" (Question 10).
Not all participants ranked all determinants as depicted in the variations in totals below in Chart 2. Notably:

- Economic Stability was selected most frequently as a social determinant of health faring poorly in Essex County;
- Social and Community Context was seleceted most frequently as a social determinant of health faring excellently.



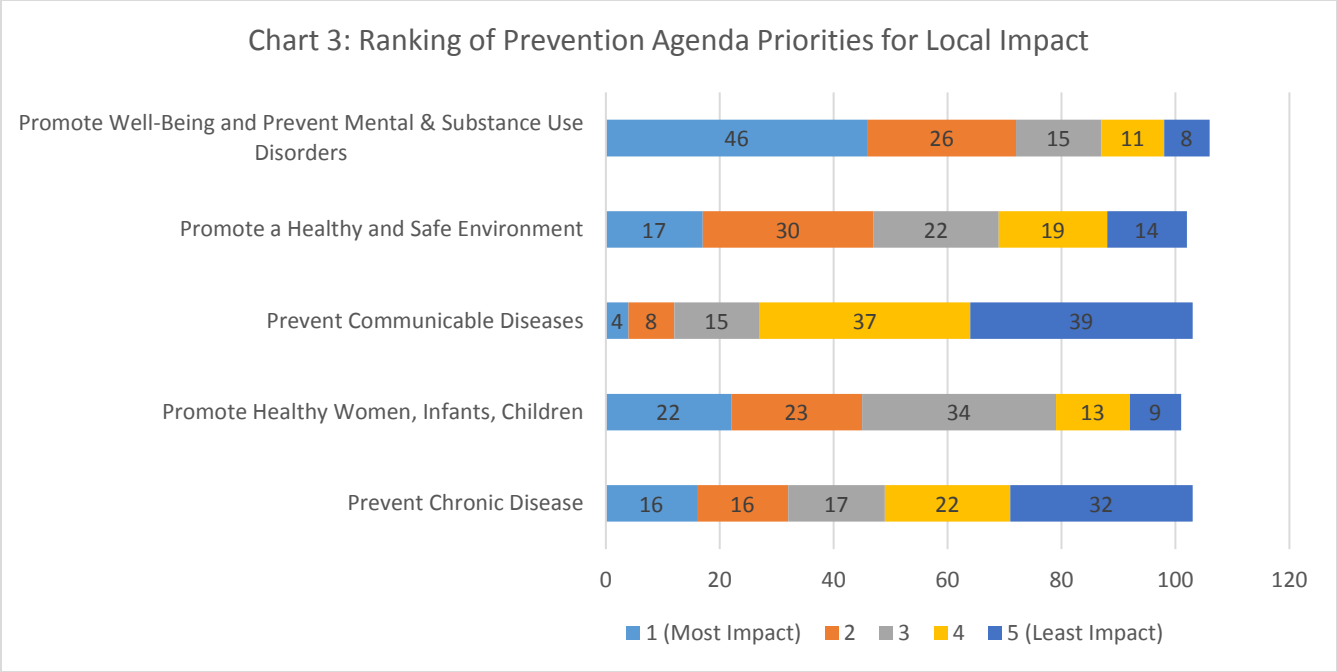
From a list of 10, **sub-populations experiencing the poorest health outcomes** (Question 11) were identified most frequently by respondents as:

1. Individuals living at or near the federal poverty level (~46%) and
2. Individuals with mental health issues (~24%)

Prevention Agenda Priorities & Goals

Participants were asked to **rank the 5 New York State Department of Health Prevention Agenda priority areas** that if addressed locally would have the greatest to smallest impact on improving the health and well-being of residents (Question 7).

Not all participants ranked all determinants as depicted in the variations in totals below in Chart 3. This chart displays the ranked order for each priority area. Notably, the priority that would have the most local impact as identified by respondents that serve Essex County was Promote Well-Being and Prevent Mental and Substance Use Disorders.

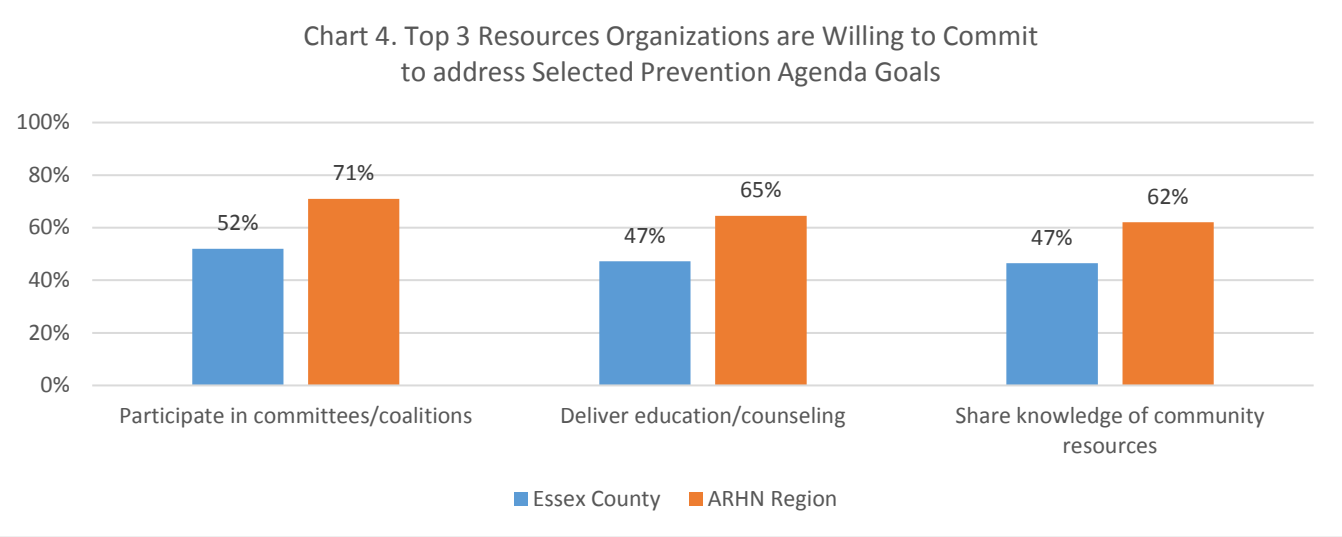


Participants were later asked to identify **specific goals of Prevention Agenda priorities that their organization could assist in achieving** (Question 12). Table 1 shows responses to this question for Essex County; goals in shaded cells were also selected regionally as identified in the ARHN Summary Report. Most Essex County goals match regionally identified goals.

Table 1: Prevention Agenda Goals identified by stakeholders as those with which their organizations could assist

NYS Prevention Agenda Priority Areas	Goal # 1	Goal # 2	Goal # 3
Prevent Chronic Disease	Improve Self-management skills for individuals with chronic disease.	Promote school, child care and worksite environments that support physical activity for people of all ages and abilities.	Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use.
Promote Healthy Women, Infants and Children	Support and enhance children and adolescents' social-emotional development and relationships.	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age.	Increase supports for children with special health care needs.
Promote a Healthy & Safe Environment	Promote healthy home and school environments.	Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate.	Reduce violence by targeting prevention programs to highest risk populations.
Promote Well-Being and Prevent Mental and Substance Use Disorders	Strengthen opportunities to promote well-being and resilience across the lifespan.	Facilitate supportive environments that promote respect and dignity for people of all ages.	Prevent opioid and other substance misuse and deaths.
Prevent Communicable Disease	Improve vaccination rates.	Reduce inappropriate antibiotic use.	Improve infections control in health care facilities.

A follow-up question related to the goals was **resources your organization/agency can contribute** to achieve those goals (Question 13). Responses for the top 3 frequently selected options [from a list of 18 + Other] are displayed in Chart 4. These 3 resources were identified most frequently by organizations that serve Essex County and across the ARHN region.



When asked if **interested in being contacted at a later date to discuss these identified resources** (Question 14) only 89 participants responded; 57 (64%) replied Yes; 32 (36%) replied No.

The final question (Question 15) asked for **additional comments/recommendations about improving the health and well-being of the residents** of counties served by the responding organization/agency. Only 14 responses were collected; they are categorized and listed here as bullets:

- Well-Being Promotion/Mental Health/Substance Abuse Prevention
  - availability of treatment on demand for opioid abuse
  - Need for Mental Health services paramount
  - We are comprised of a broad range of professionals who work with young children and families across service sectors and are dedicate to make sure that every family in our region has the supports and services they need to raise healthy happy children
- Chronic Disease Prevention
  - Facilitate more outdoor play time for children. Good for every aspect of life.
  - Caregiver support initiatives regardless of diagnosis; home care for people who need it regardless of payer
- Communicable Disease Prevention
  - More tick survey and better diagnostics.
- Cross-Cutting Issues
  - As noted earlier, addressing poverty and all its attendant issues is critical for our area.
  - Transportation is the #1 concern for our community members.
  - Question 10 is not allowing me to rate scale, but forces me to rank. None of those would be "excellent"
- Miscellaneous
  - I see great progress in our progress towards better health - am very optimistic!
  - I will be interested in reviewing the findings from this survey.
  - I work entirely with commercial farmers which has informed most of my answers. Thanks for doing this!
  - Our primary group is students, but would like to extend our involvement in community health as able.
  - none at this time

Discussion

Participation

Given only 39 of the original targeted 170 stakeholders engaged in the survey, future efforts will benefit from ongoing assessment of participation and encouragement of stakeholders to provide their valuable input. Instructing stakeholders to not share the survey link widely within their organizations will also help ensure the target audience as strategically identified is captured in responses. Essex County Health Partners did not have the capacity to tease out duplicate participants or those that had participated as the result of the link being shared with them. All responses as collected by ARHN were included in this analysis.

Health Concerns (Q8) and Contributing Factors (Q9) were asked in lists to guide the reader through thought and categorize responses for analysis. However, long lists for these two questions make it difficult for the reader to track options most especially in an electronic version. Contributing factors (Q9) were not tied to a specific concern (Q8).

Design

The electronic launch of the survey and limited questions and time necessary to take the survey facilitated participation for stakeholders.

The use of long lists such as in questions 8 (43 options) and 9 (50 options), most especially in electronic format, may have made for challenging responses. While more difficult to compile & analyze, an open ended request for these questions of health concerns and contributing factors may be considered in future surveys.

Questions that used ranking of options- 7 on Prevention Agenda Priorities and 10 on Social Determinants of Health - experienced reduced completion of the question and did not yield clear results. One might argue that all five areas of the Prevention Agenda and all Social Determinants of Health are important and relevant in improving local residents' health.

This survey was released before complete analysis of quantitative data. Future releases of Stakeholder Surveys may be timed differently to launch following preliminary assessment of outcome data and focus more heavily on if/how stakeholders are willing to engage in initiatives.

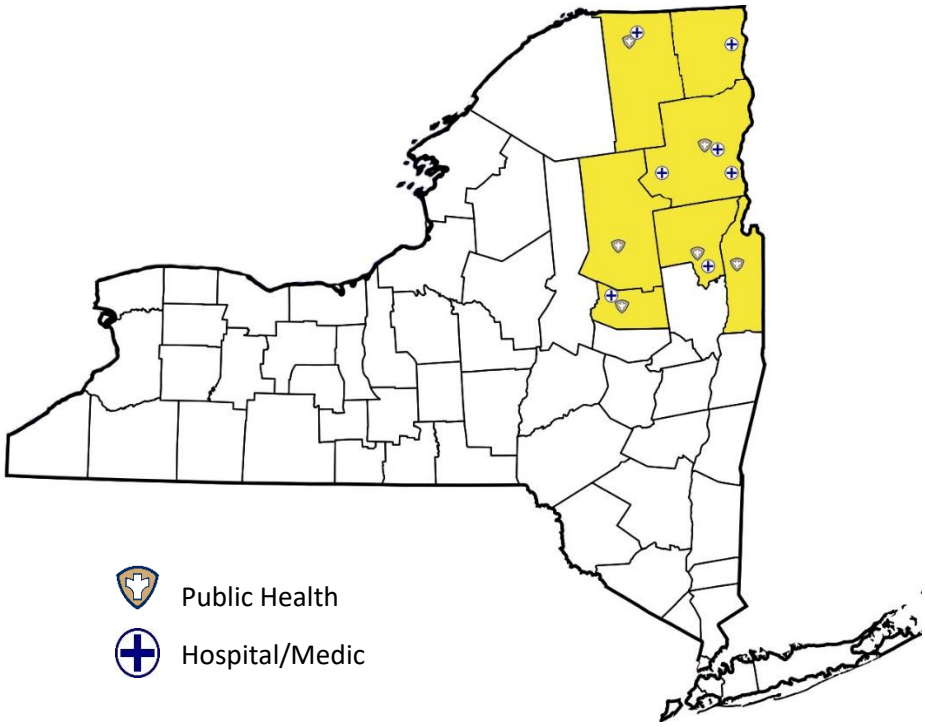
Conclusions

Stakeholders identified the **Prevention Agenda priority area** of Promote Well-Being and Prevent Mental and Substance Abuse Disorders. This directly matches 4 of the top 5 health concerns identified: Substance Abuse, Mental Health Concerns, Child/Adolescent Emotional Health & Adverse Childhood Experiences. This priority area and all goals identified as respondents as areas respective organizations could assist with match those identified in the ARHN region.

As would be expected, 4 of the top 5 **contributing factors** to the stakeholder identified priority area are nearly all related to the priority itself; those are Lack of Mental Health Services, Addiction to Illicit Drugs, Poverty, and Changing Family Structures. Economic Stability was selected most frequently as a poor social determinant of health in Essex County.

The primary **resources stakeholders identified as being available to contribut**e to improving the health of Essex County residents includes participating in committees and coalition, delivering education and counseling related to this priority issue and sharing knowledge of community resources.

Summary of 2019 Community Stakeholder Survey



Adirondack Rural Health Network Service Area

Clinton, Essex, Franklin, Fulton, Hamilton,
Warren and Washington Counties

ARHN is a program of AHI-Adirondack Health Institute
Supported by the New York State Department of Health, Office of Health Systems Management, Division of Health Facility Planning, Charles D. Cook Office of Rural Health.

April 8, 2019

Background:

Adirondack Rural Health Network: The Adirondack Rural Health Network (ARHN) is a program of AHI - Adirondack Health Institute, Inc. Established in 1992 through a New York State Department of Health Rural Health Development Grant, ARHN is a multi-stakeholder, regional coalition that informs planning, assessment, provides education and training to further the implementation of the New York State Department of Health Prevention Agenda, and offers other resources that support the development of the regional health care system. Since its inception, ARHN has provided a forum to assess regional population health needs and develop collaborative responses to priorities. ARHN includes organizations from New York's Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington counties.

Description of the Community Health Assessment Committee: Since 2002, ARHN has been recognized as the leading sponsor of formal community health planning throughout the region. The Community Health Assessment (CHA) Committee, facilitated by ARHN, is made up of hospitals and county health departments that have developed and implemented a sophisticated process for community health assessment and planning for the defined region to address identified regional priorities. The CHA Committee is made up of representatives from Adirondack Health, Clinton County Health Department, University of Vermont Health Network - Alice Hyde Medical Center, University of Vermont Health Network - Elizabethtown Community Hospital, Essex County Health Department, Franklin County Public Health, Fulton County Public Health, Glens Falls Hospital, Hamilton County Public Health, Nathan Littauer Hospital, University of Vermont Health Network – Champlain Valley Physicians Hospital, Warren County Health Services, and Washington County Public Health.

Purpose of the CHA Committee: The CHA Committee, made up of the CHA service contract holders with AHI, is a multi-county, regional stakeholder group that convenes to support ongoing health planning and assessment by working collaboratively on interventions and developing the planning documents required by the New York State Department of Health and the Internal Revenue Service in an effort to advance the New York State Prevention Agenda.

CHA Committee, Ad Hoc Data Sub-Committee: At the June 15, 2018 CHA meeting, it was decided that an Ad Hoc Data Sub-Committee would be created to review tools and processes used by CHA Committee members to develop their Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP), as well as identify ways to enhance the CHA/CHIP process. A primary activity of the Ad Hoc Data Sub-Committee was to collaboratively develop a stakeholder survey.

The data subcommittee met seven times from mid-July through the end of October 2018. Meetings were held via conference call/webinar. Attendance ranged from 10 to 12 subcommittee members per meeting. Meetings were also attended by AHI staff from ARHN, Population Health Improvement Program (PHIP) and Data teams.

Survey Methodology:

Survey Creation: The 2019 Community Stakeholder Survey was drafted by the Ad Hoc Data Sub-Committee, with the final version approved by the full CHA Committee at December 7, 2018 meeting.

Survey Facilitation: ARHN surveyed stakeholders in the seven-county service area, to provide the CHA Committee with input on regional health care needs and priorities. Stakeholders included professionals from health care, social services, educational, and governmental institutions as well as community

members. The ARHN region is made up of Clinton, Essex, Franklin, Fulton, Hamilton, Warren and Washington Counties.

Survey Logistics: The survey was developed through SurveyMonkey and included 14 community health questions as well as several demographic questions. The CHA Committee provided a list of health care, social service, education, government, and service providers (hereafter referred to as community stakeholders) by county to be surveyed. The collected distribution list totaled 807 community stakeholders.

An initial email was sent to the community stakeholders in early January 2019 by the CHA Committee partners, introducing and providing a web-based link to the survey. A follow-up email was sent by ARHN staff approximately two weeks later after the initial reach out. CHA Committee members were provided the names of all non-respondents for additional follow-up, at partner discretion.

The survey requested that community stakeholders identify the top two priority areas from a list of five which they believe need to be addressed within their county. Community stakeholders also gave insight on what they felt were the top health concerns and what contributing factors were most influential for those specific health concerns. A full list of survey questions can be found under Appendix A.

Survey Responses and Analysis: A total of 409 responses were received through February 8, 2019, for a total response rate of 50.68%. Respondents were asked to indicate in which counties they provided services and could choose coverage of multiple counties, as appropriate. The total response count per county is outlined in the *By County* section. It took respondents an average of 22 minutes to complete the survey, with a median response time of approximately 17 minutes.

Analysis is sorted alphabetically and in order of how the questions were listed in the survey to make the analysis easier to comprehend. Each table is labeled to identify whether the information is by response count or percentage. For tables containing counties, the table below indicates table is color coded to identify counties . All written analysis for each section is provided, with table below, and all written results are done in percentages.

This report provides a regional look at the results thru a wide-angle lens, focusing on the Adirondack Rural Health Network (ARHN) service area. It provides individual analyses of Clinton, Essex, Franklin, Fulton, Hamilton, Warren and Washington counties. This stakeholder survey was conducted to gather information from a variety of fields and perspectives to provide valuable insight into the community's needs. The results enable us to guide strategic planning throughout the Adirondack region, for partners who serve individual counties, and those whose footprint covers multiple counties.

Clinton
Essex
Franklin
Fulton
Hamilton
Warren
Washington

Summary Analysis

1. Indicate county/counties served

Respondents were asked which county their organization/agency serves. Over 68% of respondents were from Essex and Washington counties. Approximately 16% of respondents listed the county they serve as outside of the seven ARHN counties, including Montgomery, Saratoga and St. Lawrence counties. Twelve percent of respondents identified themselves as serving the Adirondack/North Country region as a whole.

It should be noted that the figures below may not add up to 100%, due to organizations with multiple county coverage areas.

Respondents by County		
County/Region	**Total Response Count**	**Total Response Percentage**
Adirondack/North Country Region	49	12.04%
Clinton	81	19.90%
Essex	129	31.70%
Franklin	82	20.15%
Fulton	50	12.29%
Hamilton	69	16.95%
Warren	92	22.60%
Washington	150	36.86%
Other	65	15.97%

*Figures do not add up to 100% due to multiple counties per organization.

2. Indicate the community sector that best describes your organization

Community stakeholders were asked to indicate one community sector that best described their organization or agency. Over 160 organizations responded to the survey, spanning multiple counties in the ARHN region. Respondents provided a wide range of services, including *Education (19.0%)*, *Health Care (13.2%), Social Services (12.5%), Public Health (9.2%), and Health Based Community Based Organizations (CBO) (7.5%),* among many others.

Response Counts by Community Sector	
Community Sector	**Total**
Business	4
Civic Association	3
College/University	7
Disability Services	10
Early Childhood	9
Economic Development	6
Employment/Job Training	2
Faith-Based	3
Food/Nutrition	10
Foundation/Philanthropy	1
Health Based CBO	30
Health Care Provider	53

Health Insurance Plan	1
Housing	7
Law Enforcement/Corrections and Fire Department	10
Local Government (e.g. elected official, zoning/planning board)	29
Media	2
Mental, Emotional, Behavioral Health Provider	22
Public Health	37
Recreation	3
School (K – 12)	69
Seniors/Elderly	28
Social Services	50
Transportation	2
Tribal Government	1
Veterans	2

3. Indicate your job title

Approximately 42.64% of respondents listed themselves as an *Administrator or Director.* There was a significant number of respondents who identified their title as Other (22.69%). Of those responses, the majority included teachers or education professionals and program coordinators.

It's important to note that based off responses, there did not seem to be enough answer choices. Moving forward, a recommendation would be to broaden answer choices to incorporate more community stakeholders.

Respondent Job Titles		
Job Title	**Responses**	
	Count	**Percentage**
Community Member	5	1.25%
Direct Service Staff	94	23.44%
Program/Project Manager	40	9.98%
Administrator/Director	171	42.64%
Other	91	22.69%

4. NYS Prevention Agenda Priority Areas

Top Priority Area for the ARHN Region:

Survey participants were asked to rank the NYS Prevention Agenda Priority Areas in order of most to least impact. Overall, respondents in the ARHN region identified *Promote Well-Being and Prevent Mental and Substance Use Disorders* (41.7%) as their top priority, followed by *Promote a Healthy and Safe Environment* (21.9%).

NYS Prevention Agenda Top Priority Area for the ARHN Region		
County	**First Choice**	**Second Choice**
ARHN Region	Promote Well-Being and Prevent Mental and Substance Use Disorders	Promote a Healthy and Safe Environment

Top Priority Area by County:

To analyze the chosen priority areas, responses were totaled per county and the priority area that received the most responses is listed as the *First Choice*, followed by the second most responses listed as *Second Choice.*

All seven of the ARHN counties identified *Promote Well-Being and Prevent Mental and Substance Use Disorders* as their top priority. Additionally, Clinton, Essex, Franklin and Fulton counties identified *Prevent Chronic Disease* as their second choice while Clinton, Essex, Warren and Washington counties identified *Promote a Healthy and Safe Environment* as their second choice. Clinton and Essex counties have an overlap due to ties.

As survey participants were not provided focus areas or goals associated with each priority area, it can be assumed that the answers for these priority areas were slightly swayed due to what partners believe *Promote Well-Being and Prevent Mental and Substance Use Disorders* represents or what they feel would be listed in that category.

NYS Prevention Agenda Top Priority Area by County		
County	**First Choice**	**Second Choice**
Clinton	Promote Well-Being and Prevent Mental and Substance Use Disorders	Tie: • Prevent Chronic Disease • Promote a Healthy and Safe Environment
Essex	Promote Well-Being and Prevent Mental and Substance Use Disorders	Promote Healthy Women, Infants and Children
Franklin	Promote Well-Being and Prevent Mental and Substance Use Disorders	Prevent Chronic Disease
Fulton	Promote Well-Being and Prevent Mental and Substance Use Disorders	Prevent Chronic Disease
Hamilton	Promote Well-Being and Prevent Mental and Substance Use Disorders	Tie: • Prevent Chronic Disease • Promote a Healthy and Safe Environment
Warren	Promote Well-Being and Prevent Mental and Substance Use Disorders	Promote a Healthy and Safe Environment
Washington	Promote Well-Being and Prevent Mental and Substance Use Disorders	Promote a Healthy and Safe Environment

*Overlapping in county choices is due to several ties in response totals.

5. In your opinion, what are the top five health concerns affecting the residents of the counties your organization/agency serves?

Health Concerns for the ARHN Region:

Community stakeholders were asked to choose what they believed to be the top five health concerns affecting the residents in the counties their organization/agency served. The choices were ranked from one, being the highest health concern, to five, indicating the lowest health concern.

Survey respondents felt that the top five health concerns affecting the residents within the ARHN region were *Mental Health (16.9%), Substance Abuse (12.3%), Opioid Use (9.5%), Overweight/Obesity (8.8%),* and *Child/Adolescent Emotional Health (5.7%).*

Response Counts for ARHN Region Health Concerns					
ARHN Region Health Concerns	**1 (Highest)**	**2**	**3**	**4**	**5 (Lowest)**
Adverse Childhood Experiences	20	20	19	13	8
Alzheimer's Disease/Dementia	19	17	8	5	9
Arthritis	1	0	2	3	1
Autism	2	2	2	2	4
Cancers	13	14	19	7	8
Child/Adolescent Physical Health	13	12	10	13	8
Child/Adolescent Emotional Health	20	36	20	22	14
Diabetes	10	14	14	6	16
Disability	4	7	5	5	11
Dental Health	1	5	5	10	14
Domestic Abuse/Violence	4	7	16	18	10
Drinking Water Quality	0	1	1	2	5
Emerging Infectious Diseases	2	1	5	1	8
Exposure to Air and Water Pollutants/Hazardous Materials	1	0	1	0	1
Falls	3	7	5	3	4
Food Safety	3	1	2	3	2
Heart Disease	7	11	9	16	12
Hepatitis C	0	0	1	2	1
High Blood Pressure	1	2	8	6	8
HIV/AIDS	0	0	1	0	2
Hunger	4	10	5	6	5
Infant Health	1	0	8	1	4
Infectious Disease	1	0	2	3	4
LGBT Health	0	1	0	1	2
Maternal Health	3	4	3	3	7
Mental Health Conditions	59	48	36	37	23
Motor Vehicle Safety (impaired/distracted driving)	0	0	1	0	7
Opioid Use	33	18	16	14	11
Overweight or Obesity	31	25	26	23	17
Pedestrian/Bicyclist Accidents	0	0	0	0	2
Prescription Drug Abuse	4	7	11	9	7
Respiratory Disease (asthma, COPD, etc.)	5	10	5	9	8

Senior Health	18	9	12	13	11
Sexual Assault/Rape	2	0	0	3	3
Sexually Transmitted Infections	2	0	0	4	4
Social Connectedness	2	4	9	18	16
Stroke	0	2	2	1	2
Substance Abuse	43	33	38	29	10
Suicide	1	5	2	2	7
Tobacco Use/Nicotine Addiction (smoking, vaping, chewing, etc.)	11	7	11	19	27
Underage Drinking/Excessive Adult Drinking	2	8	5	6	5
Unintended/Teen Pregnancy	2	1	1	4	10
Violence (assault, firearm related)	1	0	1	2	5

Health Concerns by County:

Overall, most of the health concerns identified per county aligned with the top five health concerns identified for the ARHN region. Several counties recognized health concerns outside the top five for the ARHN region. Three out of the seven ARHN counties listed *Adverse Childhood Experiences* as a top health concern in their county.

Warren and Washington county respondents felt that *Alzheimer's Disease* was a concern in their area, while Clinton and Hamilton counties included *Heart Disease* as a concern for their counties. Outliers include Hamilton County listing *Diabetes* and Fulton County listing *Tobacco Use* as a top concern in their county.

Top Five Health Concerns by County					
County	**1st**	**2nd**	**3rd**	**4th**	**5th**
Clinton	Mental Health Conditions	Overweight/Obesity	Opioid Use	Senior Health	Heart Disease
Essex	Substance Abuse	Mental Health Conditions	Child/Adolescent Emotional Health	Overweight/Obesity	Adverse Childhood Experiences
Franklin	Mental Health Conditions	Overweight/Obesity	Substance Abuse	Opioid Use	Adverse Childhood Experiences
Fulton	Mental Health Conditions	Substance Abuse	Tobacco Use	Opioid Use	Child/Adolescent Emotional Health
Hamilton	Substance Abuse	Mental Health Conditions	Overweight/Obesity	Heart Disease	Diabetes
Warren	Mental Health Conditions	Overweight/Obesity	Adverse Childhood Experiences	Substance Abuse	Alzheimer's Disease
Washington	Substance Abuse	Mental Health Conditions	Opioid Use	Alzheimer's Disease	Cancers

6. In your opinion, what are the top five contributing factors to the health concerns you chose in the previous question, affecting the residents of the counties your organization/agency serves?

Respondents were asked to identify what they believed to be the top five contributing factors to the health concerns they chose. The contributing factors were ranked from one to five, with one being the highest contributing factor and five being the lowest.

Contributing Factors for the ARHN Region:

The top five contributing factors identified by survey respondents are *Poverty (12.7%), Addiction to illicit drugs (10.9%), Changing family structures (10.6%), Lack of mental health services (10.3%), and Age of residents (8.3%).* Forty-four percent of respondents chose these factors as either the highest or second highest contributing factors for the health concerns that they had previously identified.

Response Counts for Top Contributing Factors in the ARHN Region					
ARHN Region Contributing Factors	**1 (Highest)**	**2**	**3**	**4**	**5 (Lowest)**
Addiction to alcohol	14	16	12	7	6
Addiction to illicit drugs	37	36	22	13	5
Addiction to nicotine	7	10	6	7	11
Age of residents	28	11	6	4	7
Changing family structures (increased foster care, grandparents as parents, etc.)	36	22	15	20	8
Crime/violence/community blight	0	1	2	1	4
Deteriorating infrastructure (roads, bridges, water systems, etc.)	1	0	1	0	3
Discrimination/racism	0	0	0	0	1
Domestic violence and abuse	4	6	5	4	7
Environmental quality	0	3	4	5	6
Excessive screen time	2	13	11	4	8
Exposure to tobacco smoke/emissions from electronic vapor products	1	3	5	1	3
Food insecurity	8	13	9	8	7
Health care costs	16	17	21	20	16
Homelessness	1	2	4	4	2
Inadequate physical activity	5	16	15	17	21
Inadequate sleep	0	0	2	3	3
Inadequate/unaffordable housing options	5	9	16	8	13
Lack of chronic disease screening, treatment and self-management services	3	8	7	7	4
Lack of cultural and enrichment programs	1	2	1	1	3
Lack of dental/oral health care services	1	3	0	6	7
Lack of educational opportunities for people of all ages	1	2	3	2	9
Lack of educational, vocational or job-training options for adults	1	1	0	6	1
Lack of employment options	1	3	12	7	7
Lack of health education programs	3	1	4	3	2
Lack of health insurance	3	1	4	3	3
Lack of intergenerational connections within communities	1	0	2	4	8
Lack of mental health services	35	28	27	26	9
Lack of opportunities for health for people with physical limitations or disabilities	2	0	1	4	4

Lack of preventive/primary health care services (screenings, annual check-ups)	6	5	2	3	3
Lack of social supports for community residents	4	3	10	8	9
Lack of specialty care and treatment	1	4	4	3	2
Lack of substance use disorder services	8	8	11	4	6
Late or no prenatal care	0	0	1	2	3
Pedestrian safety (roads, sidewalks, buildings, etc.)	0	0	0	0	1
Poor access to healthy food and beverage options	5	2	6	9	0
Poor access to public places for physical activity and recreation	2	3	1	3	4
Poor educational attainment	2	8	2	8	8
Poor community engagement and connectivity	6	5	4	6	14
Poor eating/dietary practices	12	15	15	17	12
Poor health literacy (ability to comprehend health information)	6	2	4	5	4
Poor referrals to health care, specialty care, & community-based support services	8	5	4	4	7
Poverty	43	18	16	16	23
Problems with Internet access (absent, unreliable, unaffordable)	0	0	0	3	2
Quality of schools	0	0	1	1	3
Religious or spiritual values	0	0	0	1	1
Shortage of child care options	0	1	3	1	3
Stress (work, family, school, etc.)	7	10	15	21	9
Transportation problems (unreliable, unaffordable)	9	13	15	13	14
Unemployment/low wages	3	6	3	8	13

Contributing Factors by County:

The majority of the ARHN counties identified contributing factors that fell in line with the overall ARHN region's top five. Another contributing factor indicated by Franklin, Hamilton and Warren counties was *Health Care Costs*.

Top Five Contributing Factors by County					
County	**1st**	**2nd**	**3rd**	**4th**	**5th**
Clinton	Poverty	Food Insecurity	Addiction to Illicit Drugs	Lack of Mental Health Services	Inadequate Physical Activity
Essex	Poverty	Lack of Mental Health Services	Changing Family Structures	Addiction to Illicit Drugs	Age of Residents
Franklin	Poverty	Lack of Mental Health Services	Addiction to Illicit Drugs	Changing Family Structures	Health Care Costs
Fulton	Lack of Mental Health Services	Poverty	Poor Eating/ Dietary Practices	Changing Family Structures	Addiction to Illicit Drugs
Hamilton	Age of Residents	Health Care Costs	Lack of Mental Health Services	Poverty	Poor Community Engagement and Connectivity
Warren	Age of Residents	Lack of Mental Health Services	Changing Family Structures	Health Care Costs	Poverty
Washington	Addiction to Illicit Drugs	Age of Residents	Poverty	Lack of Mental Health Services	Changing Family Structures

8. Please rank the following Social Determinants of Health impacting the residents of the counties that your organization/agency serves using a scale of (1) "excellent" to (5) "very poor".

This survey question asked respondents to rank the Social Determinants of Health, listed below, in order from one, excellent, to five, very poor. The table below encompasses response counts for the entire survey.

Many respondents chose *Health and Health Care (29.0%)* as the social determinant of health that they felt most impacted the residents of the counties that they serve, followed by *Economic Stability (22.4%).* Both of these specific Social Determinants of Health align with the chosen health factors and contributing factors listed previously.

Response Counts per Social Determinants of Health Ranking					
Social Determinants of Health	**1 (Excellent)**	**2**	**3**	**4**	**5 (Very Poor)**
Economic Stability (consider poverty, employment, food security, housing stability)	54	22	33	53	100
Education (consider high school graduation, enrollment in higher education, language and literacy, early childhood education and development)	50	67	66	49	27
Health and Health Care (consider access to primary care, access to specialty care, health literacy)	70	64	79	52	49
Neighborhood and Built Environment (consider access to healthy foods and beverages, quality of housing, crime and violence, environmental conditions, transportation)	35	67	61	79	43
Social and Community Context (consider social cohesion, civic participation, perceptions of discrimination and equity, incarceration/institutionalization)	32	58	73	62	38

9. In your opinion, what population in the counties your organization/agency serves experiences the poorest health outcomes?

To help determine who the target audience that has the greatest need is, we asked, in their opinion, what population, in the counties they serve, experiences the poorest health outcomes.

Every county in the ARHN region chose *Individuals living at or near the federal poverty level (33.3%)* as the population they felt had the poorest health outcomes. For six of the seven ARHN counties, excluding Hamilton, the second population with the highest responses was *Individuals with mental health issues (24.3%).* For Hamilton County, the second population believed to have the poorest health outcomes were *Seniors or Elderly (1.8%).*

Response Counts for Poorest Health Outcomes by County							
Population	**Clinton**	**Essex**	**Franklin**	**Fulton**	**Hamilton**	**Warren**	**Washington**
Children/Adolescents	0	5	1	1	2	5	4
Females of reproductive age	0	0	0	0	0	0	0
Individuals living at or near the federal poverty level	35	46	32	14	19	25	39
Individuals living in rural areas	5	6	7	2	8	12	17
Individuals with disability	1	2	0	0	0	1	0

Individuals with mental health issues	19	24	19	11	9	14	29
Individuals with substance abuse issues	2	8	4	1	6	7	16
Migrant workers	1	1	1	0	0	0	0
Seniors/Elderly	5	7	6	6	10	8	17
Specific racial or ethnic groups	0	0	0	0	0	0	0
Other (please specify)	0	1	0	1	1	1	2
Total per county	**68**	**101**	**70**	**37**	**56**	**74**	**126**

10. New York State Prevention Agenda Goals

Top Three Goals for the ARHN Region:

Respondents were asked to choose three goals that their organization could assist in achieving in their counties. The top three goals for each NYS Prevention Agenda priority area aligned with most of the individual county goals.

Top Three Prevention Agenda Goals for the ARHN Region			
NYS Prevention Agenda Priority Areas	**Goal #1**	**Goal #2**	**Goal #3**
Prevent Chronic Disease	Increase skills and knowledge to support healthy food and beverage choices	Improve self-management skills for individuals with chronic disease	Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities
Promote Healthy Women, Infants and Children	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations
Promote a Healthy and Safe Environment	Promote healthy home and schools' environments	Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change	Reduce violence by targeting prevention programs to highest risk populations
Promote Well-Being and Prevent Mental and Substance Use Disorders	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent opioid and other substance misuse and deaths
Prevent Communicable Disease	Improve vaccination rates	Improve infection control in health care facilities	Reduce inappropriate antibiotic use

Top Three Goals by County:

To align with the structure of the survey, county analysis is provided per NYS Prevention Agenda priority area.

Prevent Chronic Disease

Most of the responses contained two specific goals, *Promote the use of evidence-based care to manage chronic diseases* and *Improve self-management skills for individuals with chronic disease.* Five out of the seven ARHN counties also listed *Promote tobacco use cessation*. Washington County was the only county to include *Improving community environments that support active transportation,* which aligns with the top ARHN goals.

Priority Area: Prevent Chronic Disease			
County/Region	**Goal #1**	**Goal #2**	**Goal #3**
Clinton	Improve self-management skills for individuals with chronic disease	Promote school, child care, and worksite environments that support physical activity for people of all ages and abilities	Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use
Essex	Improve self-management skills for individuals with chronic disease	Promote school, child care, and worksite environments that support physical activity for people of all ages and abilities	Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use
Franklin	Improve self-management skills for individuals with chronic disease	Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use	Promote the use of evidence-based care to manage chronic diseases
Fulton	Improve self-management skills for individuals with chronic disease	Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use	Increase skills and knowledge to support healthy food and beverage choices
Hamilton	Improve self-management skills for individuals with chronic disease	Promote the use of evidence-based care to manage chronic diseases	Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use
Warren	Improve self-management skills for individuals with chronic disease	Increase skills and knowledge to support healthy food and beverage choices	Promote the use of evidence-based care to manage chronic diseases
Washington	Improve self-management skills for individuals with chronic disease	Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities.	Increase skills and knowledge to support healthy food and beverage choices

Promote Healthy Women, Infants and Children

All ARHN counties choose *Support and enhance children and adolescents' social-emotional development and relationships* as their number one goal. Clinton, Fulton, Hamilton, Warren and Washington counties also listed *Reduce racial, ethnic, economic and geographic disparities in maternal and child health outcomes* as one of their top three goals.

Priority Area: Promote Healthy Women, Infants and Children			
County/Region	**Goal #1**	**Goal #2**	**Goal #3**
Clinton	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations
Essex	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Increase supports for children with special health care needs
Franklin	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Increase supports for children with special health care needs
Fulton	Support and enhance children and adolescents' social-emotional development and relationships	Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations	Increase supports for children with special health care needs
Hamilton	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations
Warren	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations
Washington	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations

Promote a Healthy and Safe Environment

Promote healthy home and schools' environments was chosen as the top goal for all seven of the ARHN counties, as well as the ARHN region as a whole. *Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change* was also listed in the top three goals for every county.

Priority Area: Promote a Healthy and Safe Environment			
County/Region	**Goal #1**	**Goal #2**	**Goal #3**
Clinton	Promote healthy home and schools' environments	Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change	Reduce falls among vulnerable populations
Essex	Promote healthy home and schools' environments	Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change	Reduce violence by targeting prevention programs to highest risk populations
Franklin	Promote healthy home and schools' environments	Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change	Reduce violence by targeting prevention programs to highest risk populations
Fulton	Promote healthy home and schools' environments	Reduce violence by targeting prevention programs to highest risk populations	Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change
Hamilton	Promote healthy home and schools' environments	Reduce falls among vulnerable populations	Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change
Warren	Promote healthy home and schools' environments	Reduce falls among vulnerable populations	Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change
Washington	Promote healthy home and schools' environments	Reduce falls among vulnerable populations	Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change

Promote Well-Being and Prevent Mental and Substance Use Disorders

Strengthen opportunities to promote well-being and resilience across the lifespan and *Facilitate supportive environments that promote respect and dignity for all ages* were both within the top three goals for every county. Five counties also listed *Prevent opioid and other substance misuse and deaths* in their top three goals.

Priority Area: Promote Well-Being and Prevent Mental and Substance Use Disorders			
County/Region	**Goal #1**	**Goal #2**	**Goal #3**
Clinton	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent opioid and other substance misuse and deaths
Essex	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent opioid and other substance misuse and deaths
Franklin	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent opioid and other substance misuse and deaths
Fulton	Prevent opioid and other substance misuse and deaths	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages
Hamilton	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent and address adverse childhood experiences
Warren	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent and address adverse childhood experiences
Washington	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent opioid and other substance misuse and deaths

Prevent Communicable Diseases

All seven ARHN counties listed *Improve vaccination rates, Improve infection control in health care facilities,* and *Reduce inappropriate antibiotic use* in the top three goals that their organization can assist in improving. *Reduce the annual growth rate for Sexually Transmitted Infections (STIs)* was also included in Fulton County's top three goals.

Priority Area: Prevent Communicable Disease			
County/Region	**Goal #1**	**Goal #2**	**Goal #3**
Clinton	Improve vaccination rates	Improve infection control in health care facilities	Reduce inappropriate antibiotic use
Essex	Improve vaccination rates	Reduce inappropriate antibiotic use	Improve infection control in health care facilities
Franklin	Improve vaccination rates	Improve infection control in health care facilities	Reduce inappropriate antibiotic use
Fulton	Improve vaccination rates	Reduce inappropriate antibiotic use	Reduce the annual growth rate for Sexually Transmitted Infections (STIs)
Hamilton	Reduce inappropriate antibiotic use	Improve vaccination rates	Improve infection control in health care facilities
Warren	Improve vaccination rates	Improve infection control in health care facilities	Reduce inappropriate antibiotic use
Washington	Improve vaccination rates	Improve infection control in health care facilities	Reduce inappropriate antibiotic use

12. Based on the goals you selected, please identify the resources your organization/agency can contribute toward achieving these goals.

Respondents were asked to indicate the resources that their organization/agency would be able to contribute toward achieving the goals they listed. The table below encompasses the top ten resources listed.

Approximately 70% of all respondents identified *Participating on committees, workgroups and coalitions* and *Share knowledge of community resources* as the main resources they can contribute to help achieve the NYS Prevention Agenda goals listed above. Respondents also felt strongly that they can deliver education and counseling and provide expertise relevant to achieving the listed goals.

This is the first year that we have asked this question in the stakeholder survey. This would be a helpful resource to explore further once partners begin exacting their approved plans.

Response Counts and Percentages for Resources Organizations Can Contribute		
Resources	**Count**	**Percentage**
Participate on committees, work groups, coalitions to help achieve the selected goals	208	70.99%
Share knowledge of community resources	204	69.62%
Deliver education and counseling relevant to the selected goal(s)	189	64.51%
Provide subject-matter knowledge and expertise	182	62.12%
Promote health improvement activities/events through social media and other communication channels your organization/agency operates	164	55.97%
Facilitate access to populations your organization/agency serves	139	47.44%

Provide letters of support for planned health improvement activities	124	42.32%
Offer health related-educational materials	117	39.93%
Facilitate access to committees, work groups, coalitions currently working to achieve the selected goals	112	38.23%
Work to promote changes to policies/laws/community environment to address selected goal(s)	111	37.88%

Appendix A. 2019 Stakeholder Survey

2019 CHA Stakeholders Survey

Introduction

To help inform a collaborative approach to improving community health, the Adirondack Rural Health Network (ARHN) seeks to identify priorities, factors and resources that influence the health of residents of the Adirondack region (Clinton, Essex, Franklin, Fulton, Hamilton, Warren and Washington counties).

You have been identified as a key informant who can provide insight into health and well-being of the people your organization/agency serves. Please answer the survey questions in the context of your role within your organization/agency and in representing the population(s) your organization/agency serves.

All survey information will be held confidential and no responses will be attributed to any one individual or agency.

Your Organization/Agency

Please provide the following information about your organization/agency and yourself:

1. Organization/Agency name:

2. Your name (Please provide first and last name):

3. Your job title/role:

- ☐ Community Members
- ☐ Direct Service Staff
- ☐ Program/Project Manager
- ☐ Administrator/Director
- ☐ Other (please specify)

4. Your email address:

5. Indicate the **one** community sector that best describes your organization/agency:

- ☐ Business
- ☐ Civic Association
- ☐ College/University
- ☐ Disability Services

- ☐ Early Childhood
- ☐ Economic Development
- ☐ Employment/Job training
- ☐ Faith-Based
- ☐ Food/Nutrition
- ☐ Foundation/Philanthropy
- ☐ Health Based CBO
- ☐ Health Care Provider
- ☐ Health Insurance Plan
- ☐ Housing
- ☐ Law Enforcement/Corrections
- ☐ Local Government (e.g. elected official, zoning/planning board)
- ☐ Media
- ☐ Mental, Emotional, Behavioral Health Provider
- ☐ Public Health
- ☐ Recreation
- ☐ School (K – 12)
- ☐ Seniors/Elderly
- ☐ Social Services
- ☐ Transportation
- ☐ Tribal Government
- ☐ Veterans
- ☐ Other (please specify):

6. Indicate the counties your organization/agency serves. **Check all that apply.**

- ☐ Adirondack/North Country Region
- ☐ Clinton
- ☐ Essex
- ☐ Franklin
- ☐ Fulton
- ☐ Hamilton
- ☐ Warren
- ☐ Washington
- ☐ Other: _____

Health Priorities, Concerns and Factors

The NYS Prevention Agenda for 2019-2024 identifies five main priority areas that are key to improving the health of residents that you serve. These main priority areas are listed in question #7.

7. Please rank, **by indicating 1 through 5**, the priority areas that, if addressed locally, would have the greatest to the smallest impact on improving the health and well-being of the residents of the counties your organization/agency serves. (#1 ranked priority area would have the most impact; #5 ranked priority area would have the least impact.)

- ☐ Prevent Chronic Diseases
- ☐ Promote Healthy Women, Infants and Children
- ☐ Prevent Communicable Diseases
- ☐ Promote a Healthy and Safe Environment
- ☐ Promote Well-Being and Prevent Mental and Substance Use Disorders

8. In your opinion, what are the **top five (5) health concerns** affecting the residents of the counties your organization/agency serves? Please rank the health concerns from 1 (highest) to 5 (lowest).

- ☐ Adverse childhood experiences
- ☐ Alzheimer's disease/Dementia
- ☐ Arthritis
- ☐ Autism
- ☐ Cancers
- ☐ Child/Adolescent physical health
- ☐ Child/Adolescent emotional health
- ☐ Diabetes
- ☐ Disability
- ☐ Dental health
- ☐ Domestic abuse/violence
- ☐ Drinking water quality
- ☐ Emerging infectious diseases (ebola, zika virus, tick and mosquito-transmitted, etc.)
- ☐ Exposure to air and water pollutants/hazardous materials
- ☐ Falls
- ☐ Food safety
- ☐ Heart disease
- ☐ Hepatitis C
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Hunger
- ☐ Infant health
- ☐ Infectious disease
- ☐ LGBT health

- ☐ Maternal health
- ☐ Mental health conditions
- ☐ Motor vehicle safety (impaired/distracted driving)
- ☐ Opioid use
- ☐ Overweight or obesity
- ☐ Pedestrian/bicyclist accidents
- ☐ Prescription drug abuse
- ☐ Respiratory disease (asthma, COPD, etc.)
- ☐ Senior health
- ☐ Sexual assault/rape
- ☐ Sexually transmitted infections
- ☐ Social connectedness
- ☐ Stroke
- ☐ Substance abuse
- ☐ Suicide
- ☐ Tobacco use/nicotine addiction – smoking/vaping/chewing
- ☐ Underage drinking/excessive adult drinking
- ☐ Unintended/Teen pregnancy
- ☐ Violence (assault, firearm related)
- ☐ Other (Please specify):

9. In your opinion, what are the **top five** (**5**) **contributing factors** to the health concerns you chose in question #8? Please rank the contributing factors from 1 (highest) to 5 (lowest).

- ☐ Addiction to alcohol
- ☐ Addiction to illicit drugs
- ☐ Addiction to nicotine
- ☐ Age of residents
- ☐ Changing family structures (increased foster care, grandparents as parents, etc.)
- ☐ Crime/violence/community blight
- ☐ Deteriorating infrastructure (roads, bridges, water systems, etc.)
- ☐ Discrimination/racism
- ☐ Domestic violence and abuse
- ☐ Environmental quality
- ☐ Excessive screen time
- ☐ Exposure to tobacco smoke/emissions from electronic vapor products
- ☐ Food insecurity
- ☐ Health care costs
- ☐ Homelessness
- ☐ Inadequate physical activity
- ☐ Inadequate sleep
- ☐ Inadequate/unaffordable housing options
- ☐ Lack of chronic disease screening, treatment and self-management services

- ☐ Lack of cultural and enrichment programs
- ☐ Lack of dental/oral health care services
- ☐ Lack of educational opportunities for people of all ages
- ☐ Lack of educational, vocational or job-training options for adults
- ☐ Lack of employment options
- ☐ Lack of health education programs
- ☐ Lack of health insurance
- ☐ Lack of intergenerational connections within communities
- ☐ Lack of mental health services
- ☐ Lack of opportunities for health for people with physical limitations or disabilities
- ☐ Lack of preventive/primary health care services (screenings, annual check-ups)
- ☐ Lack of social supports for community residents
- ☐ Lack of specialty care and treatment
- ☐ Lack of substance use disorder services
- ☐ Late or no prenatal care
- ☐ Pedestrian safety (roads, sidewalks, buildings, etc.)
- ☐ Poor access to healthy food and beverage options
- ☐ Poor access to public places for physical activity and recreation
- ☐ Poor educational attainment
- ☐ Poor community engagement and connectivity
- ☐ Poor eating/dietary practices
- ☐ Poor health literacy (ability to comprehend health information)
- ☐ Poor referrals to health care, specialty care, and community-based support services
- ☐ Poverty
- ☐ Problems with Internet access (absent, unreliable, unaffordable)
- ☐ Quality of schools
- ☐ Religious or spiritual values
- ☐ Shortage of child care options
- ☐ Stress (work, family, school, etc.)
- ☐ Transportation problems (unreliable, unaffordable)
- ☐ Unemployment/low wages
- ☐ Other (please specify)

Social Determinants of Health

10. Social Determinants of Health are conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes. Please rate the following Social Determinants of Health impacting the residents of the counties that your organization/agency serves using a scale of (1) "very poor" to (5) "excellent".

- ☐ **Economic Stability** (consider poverty, employment, food security, housing stability)

- ☐ **Education** (consider high school graduation, enrollment in higher education, language and literacy, early childhood education and development)

- ☐ **Social and Community Context** (consider social cohesion, civic participation, perceptions of discrimination and equity, incarceration/institutionalization)

- ☐ **Neighborhood and Built Environment** (consider access to healthy foods and beverages, quality of housing, crime and violence, environmental conditions, transportation)

- ☐ **Health and Health Care** (consider access to primary care, access to specialty care, health literacy)

11. In your opinion, what **population** in the counties your organization/agency serves experiences the poorest health outcomes? Please select **one** population.

- ☐ Specific racial or ethnic groups
- ☐ Children/adolescents
- ☐ Females of reproductive age
- ☐ Seniors/elderly
- ☐ Individuals with disability
- ☐ Individuals living at or near the federal poverty level
- ☐ Individuals with mental health issues
- ☐ Individuals living in rural areas
- ☐ Individuals with substance abuse issues
- ☐ Migrant workers
- ☐ Others (please specify):

Improving Health and Well-Being

The NYS Prevention Agenda 2019-2024 identifies specific goals for improving the health of New Yorkers of all ages. New York State envisions that improving the health of all New Yorkers requires strategies that can be implemented by a diverse set of health and non-health organizations and agencies.

12. Over the next 5 questions, select the top 3 goals your organization/agency can assist in achieving in the counties it serves.

13. Prevent Chronic Diseases

- ☐ Increase access to healthy and affordable food and beverages
- ☐ Increase skills and knowledge to support healthy food and beverage choices
- ☐ Increase food security
- ☐ Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities
- ☐ Promote school, child care, and worksite environments that support physical activity for people of all ages and abilities
- ☐ Increase access, for people of all ages and abilities, to safe indoor and/or outdoor places for physical activity
- ☐ Prevent initiation of tobacco use, including combustible tobacco and vaping products by youth and young adults
- ☐ Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use including: low income; frequent mental distress/substance use disorder; LGBT; and disability
- ☐ Eliminate exposure to secondhand smoke and exposure to secondhand aerosol/emissions from electronic vapor products
- ☐ Increase screening rates for breast, cervical, and colorectal cancer
- ☐ Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity
- ☐ Promote the use of evidence-based care to manage chronic diseases
- ☐ Improve self-management skills for individuals with chronic disease

14. Promote Healthy Women, Infants, and Children

- ☐ Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age
- ☐ Reduce maternal mortality and morbidity
- ☐ Reduce infant mortality and morbidity
- ☐ Increase breastfeeding
- ☐ Support and enhance children and adolescents' social-emotional development and relationships
- ☐ Increase supports for children with special health care needs
- ☐ Reduce dental caries (cavities) among children
- ☐ Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations

15. Promote a Healthy and Safe Environment

- ☐ Reduce falls among vulnerable populations
- ☐ Reduce violence by targeting prevention programs to highest risk populations
- ☐ Reduce occupational injury and illness

- ☐ Reduce traffic-related injuries for pedestrians and bicyclists
- ☐ Reduce exposure to outdoor air pollutants
- ☐ Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change
- ☐ Promote healthy home and schools' environments
- ☐ Protect water sources and ensure quality drinking water
- ☐ Protect vulnerable waterbodies to reduce potential public health risks associated with exposure to recreational water
- ☐ Raise awareness of the potential presence of chemical contaminants and promote strategies to reduce exposure
- ☐ Improve food safety management

16. Promote Well-Being and Prevent Mental and Substance Use Disorders

- ☐ Strengthen opportunities to promote well-being and resilience across the lifespan
- ☐ Facilitate supportive environments that promote respect and dignity for people of all ages
- ☐ Prevent underage drinking and excessive alcohol consumption by adults
- ☐ Prevent opioid and other substance misuse and deaths
- ☐ Prevent and address adverse childhood experiences
- ☐ Reduce the prevalence of major depressive episodes
- ☐ Prevent suicides
- ☐ Reduce the mortality gap between those living with serious mental illness and the general population

17. Prevent Communicable Diseases

- ☐ Improve vaccination rates
- ☐ Reduce vaccination coverage disparities
- ☐ Decrease HIV morbidity (new HIV diagnoses)
- ☐ Increase HIV viral suppression
- ☐ Reduce the annual growth rate for Sexually Transmitted Infections (STIs)
- ☐ Increase the number of persons treated for Hepatitis C
- ☐ Reduce the number of new Hepatitis C cases among people who inject drugs
- ☐ Improve infection control in health care facilities
- ☐ Reduce infections caused by multidrug resistant organisms and C. difficile
- ☐ Reduce inappropriate antibiotic use

18. Based on the goals you selected in Questions 12-16, please identify the primary assets/resources your organization/agency can contribute toward achieving the goals you have selected.

- ☐ Provide subject-matter knowledge and expertise
- ☐ Provide knowledge of and/or access to potential sources of funding (grants, philanthropy)
- ☐ Facilitate access to committees, work groups, coalitions currently working to achieve the selected goals
- ☐ Participate on committees, work groups, coalitions to help achieve the selected goals
- ☐ Share knowledge of community resources (e.g. food, clothing, housing, transportation, etc.)
- ☐ Facilitate access to populations your organization/agency serves (to encourage participation in programs, provide feedback about health improvement efforts, etc.)
- ☐ Promote health improvement activities/events through social media and other communication channels your organization/agency operates
- ☐ Share program-level data to help track progress in achieving goals
- ☐ Provide in-kind space for health improvement meetings/events
- ☐ Offer periodic organizational/program updates to community stakeholders
- ☐ Provide staff time to help conduct goal-related activities
- ☐ Provide letters of support for planned health improvement activities
- ☐ Sign partnership agreements related to community level health improvement efforts
- ☐ Assist with data analysis
- ☐ Offer health related-educational materials
- ☐ Other (please specify):

19. Are you interested in being contacted at a later date to discuss the utilization of the resources you identified in Question #17?

- ☐ Yes
- ☐ No

20. Please add any other comments/recommendations you have about improving the health and well-being of the residents of the counties your organization/agency serves.

Appendix 8:

Master Source List

SOURCE #	SOURCE
1	Adirondack Community Action Program Community Assessment Report 2019
2	Adirondack Community Action Program Community Impact Report 2018
3	Adirondack Health Institute
4	Adirondack Park Agency Annual Report 2018
5	AHRN Data Sheets (Appendices 2 & 3; Indicator Specific)
6	Alzheimer's Association, New York Alzheimer's Statistics
7	American Journal of Public Health
8	CARES Engagement Network
9	Center for Neighborhood Technology
10	Centers for Disease Control and Prevention
11	Centers for Medicaid and Medicare Services
12	Community Commons
13	Community Engagement Network
14	Counter Tobacco, Restricting Product Availability
15	Division of Criminal Justice Services Index, Property, and Firearm Rates
16	Essex County Board of Elections, Election Archive
17	Essex County Health Department
18	Essex County Health Department WIC, Local Agency Compliance And Assessment Data Sheet
19	Essex County Real Property Tax Services Department
20	Essex County Transportation Department
21	Essex County Youth Bureau, Prevention Needs Assessment 2018
22	Federal Communications Commission (FCC)
23	Federal Communications Commission (FCC) Connect2Health Initiative
24	Feeding America
25	Health Resources and Services Administration (HRSA)
26	Healthy ADK
27	Healthy People 2020 - Social Determinants of Health
28	Kids' Well-being Indicators Clearinghouse
29	National Agricultural Statistics Service
30	National Association of County and City Health Officials
31	National Library of Medicine
32	National Center for Education Statistics

SOURCE #	SOURCE
33	National Oceanic and Atmospheric Administration
34	Network for Public Health Law
35	New York State Government, list of Agencies
36	New York State Leading Causes of Death
37	NYS Communicable Disease Electronic Surveillance System (CDESS)
38	NYS Council on Children and Families
39	NYS DOH Asthma Dashboard
40	NYS DOH Behavioral Risk Factor Surveillance System (BRFSS)
41	NYS DOH Center for Environmental Health (CEH)
42	NYS DOH Community Health Indicator Reports (CHIRs)
43	NYS DOH Creating Healthy Schools and Communities RFA
44	NYS DOH Hospital Report on Hospital Acquired Infections
45	NYS DOH Information for Action Sheets
46	NYS DOH Letter to ECHD Director, April 2018
47	NYS DOH Opioid Dashboard
48	NYS DOH Prevention Agenda
49	NYS DOH Student Weight Category Status Reporting Results
50	NYS DOH Tobacco Enforcement Compliance Results
51	NYS Education Department
52	NYS Office of Mental Health
53	NYS Office of the Comptroller
54	NYS Student Weight Status Category Reporting System (SWSCRS) Data
55	NYS Traffic Safety Statistical Repository
56	NYS Voter Enrollment by County, Party Affiliation and Status, Voters Registered as of April 1, 2016
57	Public Health Accreditation Board
58	Robert Wood Johnson Foundation County Health Rankings and Roadmaps
59	Rural Health Information Hub
60	United Way of New York State
61	University of Albany Center for Health Workforce Studies
62	US CDC Alzheimer's Disease Mortality by State
63	US Census Bureau. American Community Survey
64	US Department of Agriculture (USDA)
65	US Department of Agriculture, Economic Research Service
66	US Department of Health and Human Services (HHS)
67	US Election Atlas, 2016 Presidential General Election Results
68	Essex County Office for the Aging
69	NYS Department of Health
70	Mauldin Economics
x	Reference exists but is not confirmed for submission of this report to NYSDOH on 12/31/2019.

Appendix 9: Prioritization Matrix

PRIORITIZATION WORKSHEET
DRAFT 8.5.2019

SCORE
5 = High Impact/Need
3 = Medium Impact/Need
1 = Low Impact/Need
0 = Not Applicable

			SCOPE		SEVERITY		ABILITY TO IMPACT		COMMUNITY READINESS	
			Breadth	**Inequities/ disparities**	**Community Cost**	**Negative outcomes**	**Resource Capacity**	**Confidence**	**Stakeholder Support**	**Prevailing Community Attitude**
		DESCRIPTION	relatively high % or rate or trending poorly	identifiable sub-population(s) with greater risk	relatively high dollars/time/ social consequences	across other aspects of life & across lifespan	funds, staff, time	evidenced-based practices available; confidence in implementing interventions to produce desired outcomes	leaders, policy makers, community collaborators	Acceptance of the issue and support for interventions
PRIORITY AREAS	FOCUS AREAS	SCORE (0-5)								
Prevent Chronic Diseases	1. Healthy Eating & Food Security	**0**								
	2. Physical Activity	**0**								
	3. Tobacco Prevention	**0**								
	4. Preventive Care & Management	**0**								
Promote a Healthy & Safe Environment	1. Injuries, Violence & Occupational Health	**0**								
	2. Outdoor Air Quality	**0**								
	3. Built & Indoor Environments	**0**								
	4. Water Quality	**0**								
	5. Food & Consumer Products	**0**								
Promote Healthy Women, Infants & Children	1. Maternal & Women's Health	**0**								
	2. Perinatal & Infants Health	**0**								
	3. Child & Adolescent Health	**0**								
	4. Cross Cutting Healthy WIC	**0**								
Promote Well-bring and Prevent MH & SUDs	1. Promote Well-being	**0**								
	2. Prevent Mental & Substance Use Disorders	**0**								
Prevent Communicable Diseases	1. Vaccine-Preventable Diseases	**0**								
	2. HIV	**0**								
	3. STIs	**0**								
	4. HepC	**0**								
	5. Antibiotic Resistence & Healthcare Associated Infections	**0**								

Appendix 10
CHISP Work Plan

Name of County - Organization(s) 2019 Workplan	Adirondack Health	Essex County Health Department	UVMHN Elizabethtown Community Hospital	North Country Healthy Heart Network	Champlain Valley Family Services
Planning Report Liaison	Dan Hill, Heidi Bailey	Jessica Darney Buehler, Elizabeth Terry	Julie Tromblee, Amanda Whisher	Ann Morgan	Dana Bushy Isabella
E-mail:	dhill@adirondackhealth.org, hbailey@adirondackhealth.org	jdarneybuehler@co.essex.ny.us, eterry@co.essex.ny.us	jtromblee@ech.org, awhisher@ech.org	amorgan@heartnetwork.org	tobaccofree@cvfamilycenter.org

Priority	Focus Area (select one from drop down list)	Goal Focus Area (select one from drop down list)	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s) and Resources
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.0 Reduce obesity and the risk of chronic disease	Objective 1.4 Decrease the percentage of adults ages 18 years and older with obesity (among all adults) Target 23.2% Baseline 32.2% Baseline Year 2016 Data Source BRFSS Data Level State (by sex, age, race/ethnicity, income educational attainments, disability and region), county	Access - The rural setting limits individuals from accessing services and programs outside of their communities.	Intervention 1.0.3 Worksite nutrition and physical activity programs designed to improve health behaviors and results Local health departments, hospitals, health centers, businesses, CBOs and other stakeholders can implement wellness programs at their own worksite and work with local worksites to implement nutrition and physical activity interventions as part of a comprehensive worksite wellness program. Recommended components include: • Educating and informing through classes, distributing written information or utilizing educational software. • Conducting activities that target thoughts and social factors to influence behavior change. Examples include individual or group behavioral counseling, skill-building activities, providing rewards, and building support systems among co-workers and family members. • Changing physical or organizational structures that reach the entire workforce and make the healthy	Number of individuals utilizing services	UVMHN-Elizabethtown Community Hospital increased access for physical activity to include both the Elizabethtown and Ticonderoga campuses in addition to Elizabethtown Community Health Center. Both inpatient and outpatient physical therapy facilities are open access with a buddy system for employees.	The hospital will investigate expanding hours of operation for staff to utilize the facility. Recruitment for staff members trained in CPR to volunteer in Physical Therapy to allow for extended patient use. ECH will also develop and implement a workplace Take Off Pounds Sensibly (TOPS) program to be offered to ECH employees by January 2021.	Should the TOPS program be successful the hospital will open the program up to community partners by September 2021. The possibility of physical activity classes such as yoga will be made available for staff to attend, dependent on space.	Hospital	ECH will maintain documentation of enrollment in both the physical activity and nutrition programs. Resources: https://www.cdc.gov/workplacehealthpromotion/index.html https://www.tops.org/tops/TOPS/About_TOPS.aspx
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.0 Reduce obesity and the risk of chronic disease	1.0.4 - Increase the number of schools that improve nutrition policies and practices in at least 3 of 11 school districts in Essex County in an effort to reduce childhood obesity rates from 21% to the NYS Prevention Agenda benchmark of 16.7% by December 2021.	Socioeconomic, Neighborhood and Built Environment (Limited access to healthy foods and physical activity. Examples: sidewalks and grocery stores).	Collaborate with local school districts to implement multi-component school-based obesity prevention interventions to include policy and environmental changes that target physical activity and nutrition (PA&N) before, during and/or after school.	*Input measures: provide assessment, targeted technical assistance to school wellness committees to support their efforts to improve, communicate and implement their school wellness policies. *Output measures: Three school districts will demonstrate improved implementation of policies and practices in three areas: 1) Nutrition Standards for Competitive Foods and Other Foods and Beverages; 2) Physical Education and Physical Activity; 3) School Wellness Promotion and Marketing (assessment tool: NYS DoH CHSC Building Assessment) *Short-term Outcome: Number of school districts with Wellness Committees meeting 3 x per year with goals related to implementation and having complete pre-assessments. *Intermediate Outcome: Number of school districts with improved implementation of policies and practices related to PA&N having completed post-assessments. *Long-term Outcome: reduction in overweight and obese school-aged children in the three targeted school districts.	Creating Healthy Schools & Communities in Clinton and Essex Counties (CHSC) will provide pre/post assessment and targeted technical assistance to three of the highest risk Essex County School Districts, to support their implementation of policies and practices to increase PA&N.	Creating Healthy Schools & Communities in Clinton and Essex Counties (CHSC) will provide pre/post assessment and targeted technical assistance to three of the highest risk Essex County School Districts, to support their implementation of implement policies and practices to increase PA&N. Essex County Health Department (ECHD) will offer technical assistance to school districts located outside of the CHSC catchment by creating and distributing a survey based on the School Building Assessment survey with the intention of analyzing results, providing feedback, and recommending resources needed for improvement. Results of the survey and recommendations for improvement will be provided to schools and will be available for communities and potential partners.	ECHD will offer technical assistance to school districts located outside of the CHSC catchment by creating and distributing a survey based on the School Building Assessment survey with the intention of analyzing results, providing feedback, and recommending resources needed for improvement. Results of the survey and recommendations for improvement will be provided to schools and will be available for communities and potential partners.	K-12 School	School district Wellness Committees and administrative leaders meet regularly with CHSC and/or ECPH specialists to review and enact recommendations (provided through assessment) to improve implementation of school wellness policies.
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.1 Increase access to healthy and affordable foods and beverages	Objective 1.9 Decrease the percentage of adults who consume less than one fruit and less than one vegetable per day (among all adults) Target 29.6% Baseline 31.2% Baseline Year 2016 Data Source BRFSS Data Level State	Socioeconomic (Income) - Target ALICE families to participate in the program.	Intervention 1.0.5 Increase the availability fruit and vegetable incentive programs Systematic evidence reviews find that financial incentive programs can increase affordability, access, purchases, and consumption of fruits and vegetables. Incentive programs for the purchase of fruits and vegetables have also been shown to increase sales and use of food assistance benefits (e.g., SNAP or WIC) at farmers' markets. Financial incentives can be a dollar-for-dollar match or a set amount per dollar spent (i.e., $2 for every $5 spent). Local health departments, hospitals, health centers, insurers, businesses, CBOs, hunger prevention advocates and other stakeholders can collaborate with local agencies to increase the availability and/or provide matching funds for low-income persons to purchase healthy foods, especially fresh fruits and vegetables.	Number of participants and Number of vouchers redeemed	Wellness RX was a program developed by Elizabethtown Community Hospital to address the dietary crisis in our community. Designed as a referral based program, Wellness RX is open to all patients of the UVMHN-ECH network. Participants are required to attend monthly education sessions with a diabetic educator or nutritionist in exchange for vouchers that can be redeemed for fruits and vegetables at local grocers and farmer's markets. There are currently eight redemption sites throughout the county.	The hospital will maintain established relationships with community partners and remain active in the county led Well Fed Collaborative. ECH will increase the total number of participating redemption sites by at least four and will continue to promote the Wellness RX program. ECH will have at least 55 participants by December 2020.	The hospital will continue to develop the program and identify sustainment activities. Physical activity will be incorporated to the program by September 2021.	Hospital	ECH will maintain documentation of participation and progress for statistical calculations. Resources: https://www.wholesomewave.org/ https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/fruit-vegetable-incentive-programs
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.3 Increase food security	1.0.6 - Increase the number of health practices that screen for food insecurity and facilitate referrals to supportive services in at least 5 Essex County health practices by December 2021.	Socioeconomic (Income) - Target ALICE families to participate in the program.	Intervention 1.0.6 Screen for food insecurity, facilitate and actively support referral Effective systems for referral are necessary to help individuals and families access services and benefits for which they eligible. Screening for food insecurity in clinical settings has been recommended by several national organizations, as food insecurity can adversely impact a patient's health outcomes. Some studies have shown that screening for food insecurity is feasible and adds minimal time to the appointment. Screening can ensure timely referral to public health nutrition programs such as WIC, SNAP, CACFP and Commodity Supplemental Food Program (CSFP), and, if necessary, local emergency food services. Screening and referral alone, however, may not be sufficient. Successful case studies have included additional information technology (IT), systems and/or staff resources to facilitate connection, application, and enrollment in the appropriate public health nutrition and/or community program(s). Local hospitals, health centers, businesses, and other stakeholders can partner with CBOs and governmental or private human services organizations to: • Promote and support screening of pediatric patients	Number of individuals screened for food secuity and Pounds of food provided Input Measures: # of technical assistance meetings held, # of screening tools shared Output Measures: # of health networks engaged Short-term Outcome: implementation or improvement plans created, # new food insecurity screening policies/procedures adopted Intermediate Outcome: Patients are being screened for food security during medical appointments. Long-term Outcome: Food insecurity screening procedure is in place, patients are being screened and referred to nutrition incentive programs as needed.	UVMHN-Elizabethtown Community Hospital established a co-located food pantry in the Crown Point Health Center. A food security screening is being designed to be added to the EHR. Invidividuals and families who screen positive for food insecurity will be referred to the Crown Point Health Center food pantry where they will be given a five day supply of food and offered referrals to additional recources throughout the community, for exam SNAP navigation. Essex County Health Department (ECHD) will reach out to Adirondack Medical Center (AMC), University of Vermont Health Network - Elizabethtown Community Hospital (UVHN - ECH) , and Hudson Headwaters Health Network (HHHN) to determine current practice of screening for food insecurity for patients in the health center and hospital settings.	ECH will submit an application to join the regional food bank. If approved the cost reduction of purchasing food will allow for the sustainability of the pantry. ECHD will work with interested health practices on brainstorming potential options (based on evidenced based practices) to add food insecurity screening questions onto existing medical records or assist in creating an additional policy/procedure to screen patients and refer patients in need to public health nutrition programs such as SNAP, WIC, local food pantry services, and other nutrition programs when applicable.	ECH will continue to established relationships throughout the community to further connect individuals in need. The hospital will continue to have representation at Well Fed Collaborative meetings. ECHD will provide health practices with a list of nutrition incentive programs and resources to make referrals. ECHD will also work with participating health networks on gathering data on how many people received food insecurity screening and how many referrals were made to nutrition incentive programs. ECHD will also reach out to Essex County Mental Health (ECMH), Mental Health Association of Essex County (MHA), and St. Joseph's Addiction Treatment Center to access current food security screening and referral process to provide assistance if necessary.	Hospital	ECH will maintain documentation of screenings completed and amount of food distributed. ECHD - Assist in identifying possible screening tools/methods, share nutrition incentive programs and resources, gather data for reporting. UVHN-ECH, AMC, HHHN, ECMH, MHA - Access current practice, implement policy/procedure to screen for food security, screen patients for food security and make referrals to nutrition incentive programs as necessary. Resources: https://hungerandhealth.feedingamerica.org/explore-our-work/community-health-care-partnerships/addressing-food-insecurity-in-health-care-settings/

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E-mail:	dhill@adirondackhealth.org , hbailey@adirondackhealth.org	jdarneybuehler@co.essex.ny.us, eterry@co.essex.ny.us	jtromblee@ech.org, awhisher@ech.org	amorgan@heartnetwork.org	tobaccofree@cvfamilycenter.org	

Priority	Focus Area (select one from drop down list)	Goal Focus Area (select one from drop down list)	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s) and Resources
Prevent Chronic Diseases	Focus Area 3: Tobacco prevention	Goal 3.2 Promote tobacco use cessation	3.2.1 - Increase (or maintain) % of medical and behavioral health provider systems serving Essex County residents that have adopted Public Health Service (PHS) guideline concordant policies for treatment of tobacco addiction to at least 75% (Medical Baseline: 100%; Behavioral Baseline: 33%) by December 2021.	Health Care Access	Assist medical and behavioral health care organizations (defined as those organizations focusing on mental health and substance use disorders) and provider groups in establishing policies, procedures and workflows to facilitate the delivery of tobacco dependence treatment, consistent with the Public Health Service Clinical Practice Guidelines, with a focus on Federally Qualified Health Centers, Community Health Centers and behavioral health providers. Evidenced Based Intervention - Treating Tobacco Use and Dependence - Public Health Services Guideline (2008 edition)https://www.ahrq.gov/prevention/guidelines/tobacco/index.html	Number of patients who quit and sustained smoking cessation. Input Measures: Administrative presentations offered; Improvement process trainings offered; Planning meetings held; Model policies shared Output Measures: # presentations/trainings offered; # Memorandum of understanding (MOU); # planning meetings held Short-term Outcome: # policy development, implementation or improvement plans created; # new policies/standards of care adopted Intermediate Outcome: Tobacco using patients report received assistance from their health care provider to quit smoking; increased utilization of cessation benefits (counseling and/or medication) Long-term Outcome: Decrease in prevalence of adult tobacco use	Identify medical and behavioral health systems serving Essex County residents and assess current PHS guideline concordant policy adoption status. Establish baseline measures for quality improvement that focuses on increasing provider delivery of an advice statement per evidence-based guidance.	Provide technical assistance for adoption of PHS guideline concordant policy to at least one behavioral health system. Provide ongoing support to medical and behavioral health systems with PHS guideline concordant policies to ensure ongoing improvement of tobacco treatment policy implementation. Standing order followed and administered by health center clinical staff.	Provide technical assistance for adoption of PHS guideline concordant policy to remaining medical and behavioral health systems where policies have not yet been adopted. Provide ongoing support to medical and behavioral health systems with PHS guideline concordant policies to ensure ongoing improvement of tobacco treatment policy implementation. Implement and maintain workflow to ensure all essential providers are screening for tobacco use.	Providers	Providers adopt and implement PHS guideline concordant policies. Health Systems for a Tobacco Free NY contractor (Year 1 - North Country Healthy Heart Network) provides technical assistance and patient and/or provider education materials to all health system providers in the county. Health system grantee will provide support on policy implementation and the development of standards of care as the Lead for this intervention. Franklin County Public Health Department will assist by communicating and promoting hospital resources to reach a larger group, provide subject matter expertise to keep hospital attuned to health disparities in the county and connect to healthcare resources.
Prevent Chronic Diseases	Focus Area 3: Tobacco prevention	Goal 3.2 Promote tobacco use cessation	3.2.3 - Engage at least 3 health providers (medical and behavioral health) in Essex County in the Talk to Your Patients Campaign by December 2021.	Economic Stability, Health & Health Care	Use health communications targeting health care providers to encourage their involvement in their patients' quit attempts encouraging use of evidence-based quitting, increasing awareness of available cessation benefits (especially Medicaid), and removing barriers to treatment. Evidenced Based Intervention: https://talktoyourpatients.health.ny.gov/	Number of media and marketing outreach encounters. Number of providers participating in smoking cessation campaigns. Input Measures: Planning meeting structure Output Measures: # Meetings held; Implementation Plans created; campaign materials distributed Short-term Outcome: % tobacco using patients "advised" to quit tobacco increases Intermediate Outcome: Tobacco using patients report received assistance from their health care provider to quit smoking; increased utilization of cessation benefits (counseling and/or medication) Long-term Outcome: Decrease in prevalence of adult tobacco use	Identify medical health system to pilot implementation of campaign. Establish baseline measures for quality improvement that focuses on increasing provider delivery of an advice statement per evidence-based guidance.	Provide technical assistance for implementation of Talk to Your Patients campaign in at least one medical provider system. Recruit at least two behavioral health systems to implement campaign in Year 3.	Provide technical assistance for implementation of Talk to Your Patients campaign in at least two behavioral health systems. Provide ongoing support for continued implementation of Talk to Your Patients campaign in health systems that began implementation in year 2.	Providers	Providers participate in campaign implementation planning process; then monitor implementation. Health Systems for a Tobacco Free NY contractor (Year 1 - North Country Healthy Heart Network) provides technical assistance and campaign materials to participating provider systems.
Prevent Chronic Diseases	Focus Area 3: Tobacco prevention	Goal 3.2 Promote tobacco use cessation	3.2.1 Increase the percentage of smokers who received assistance from their health care provider to quit smoking by 13.1% from 53.1% (2017) to 60.1%. Target 60.1% Baseline 53.1% Baseline Year 2017 Data Source NYS ATS Data Level State (race/ethnity, gender, SES, NYC/ROS)	Socioeconomic - Medicaid Recipients	3.2.3 Use health communications targeting health care providers to encourage their involvement in their patients' quit attempts encouraging use of evidence-based quitting, increasing awareness of available cessation benefits (especially Medicaid), and removing barriers to treatment.	Number of individuals screened for tobacco use and Number of individuals who participate in tobacco cessation	EHR modifications have been completed to capture patients who use tobacco products. A policy has been developed to refer patients who are positive for tobacco use to tobacco cessation specialist (ECH currently has two.)	A third cessation specialist will be identified and trained. Their presence at health fairs and community events will increase by 10%. Community engagement will expand to include social centers, fire houses, and additional health fairs. Hosting public forums with partners to increase community awareness.	ECH will offer tobacco cessation services in community event space (eg. Essex County Fair.) Health fairs will expand to health center locations.	Hospital	ECH will maintain documentation of referrals to tobacco cessation and the number of individuals screened throughout the year. Resources: https://talktoyourpatients.health.ny.gov/
Prevent Chronic Diseases	Focus Area 3: Tobacco prevention	Goal 3.3 Eliminate exposure to secondhand smoke	3.3.1 - 25 additional apartment units will receive 100% smoke-free multi-unit housing certification though policy adoption by December 2021.	Economic Stability, Neighborhood & Built Environment	Promote smoke-free and aerosol-free (from electronic vapor products) policies in multi-unit housing, including apartment complexes, condominiums and co-ops, especially those that house low-SES residents using evidence-based strategies. Evidenced Based Intervention - https://www.hud.gov/program_offices/healthy_homes/smokefree	Input Measures: Planning meetings held Output Measures: # Meetings held, draft policies created, campaign materials created and distributed Short-term Outcome: # of landlords/property managers engaged in smoke-free housing program increases Intermediate Outcome: # of apartments with 100% smoke - free housing policies adopted and implemented increases Long-term Outcome: % of people exposed to second hand smoke decreases	Essex County Health Department (ECHD) and Champlain Valley Family Center Advancing Tobacco Free Communities (ATFC) met to discuss potential goals and possible collaboration opportunities.	CVFC ATFC will research current multi-unit housing options in Essex County to establish a baseline for smoke - free housing policies. CVFC ATFC will also increase multi unit housing that has 100% smoke free policies by 10 units in Essex County.	CVFC ATFC will increase multi-unit housing that has 100% smoke free policies by 15 units.	Housing	CVFC ATFC - Facilitate and support smoke free housing policy planning and implementation. Landlords/Property Managers - Adopt and implement smoke free housing policies.
Prevent Chronic Diseases	Focus Area 3: Tobacco prevention	Goal 3.3 Eliminate exposure to secondhand smoke	3.3.2 - Increase the number of smoke-free parks, beaches, playgrounds and other public spaces by 2 additional locations by December 2021.	Neighborhood & Built Environment	Increase the number of smoke-free parks, beaches, playgrounds, college and other public spaces using evidence-based strategies to reduce exposure to second hand smoke. Evidenced Based Intervention - http://tobaccopolicycenter.org/tobacco-control/tobacco-free-outdoor-areas/	Input Measures: Planning meetings held Output Measures: # Meetings held, draft policies created, campaign materials created and distributed Short-term Outcome: # of municipal leaders/organizational decision makers engaged in smoke-free communities program increases Intermediate Outcome: # of parks, beaches, playgrounds, and other public spaces with 100% smoke - free policies adopted and implemented increases Long-term Outcome: % of people exposed to second hand smoke decreases	ECHD and CVFC ATFC met to discuss goal and possible collaboration opportunities.	Establish baseline and increase by one municipal and one public (NCCC)	Increase by one municipal and one public (Essex Centers)	Other (please describe partner and role(s) in column D)	CVFC ATFC - Facilitate and support tobacco free grounds policy planning and implementation. Municipal leaders/Organizational Decision Makers - Adopt and implement smoke free parks, beaches, playgrounds, and other public spaces policies
	Focus Area 4: Preventive care and management	Goal 4.1 Increase cancer screening rates	Increase the percentage of adults who receive a colorectal cancer screening based on the most recent guidelines (ages 50 to 75 years)	Income, Access, Disability	4.1. Systems change for cancer screening reminders	Number of patients reached through patient reminder systems and compliance with Cancer screening guidelines.	Review current practice for reliability and timeliness to ensure reminders are being sent by all providers	Continue to track patient reminders	Continue to track patient reminders	Community-based organizations	Health system grantee will parnter and support this intervention. Franklin County Public Health Department will assist by communicating and promoting hospital resources to reach a larger group, provide subject matter expertise to keep hospital attuned to health disparities in the county and connect to healthcare resources.
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.1 Increase cancer screening rates	4.1.1 Increase the percentage of women with an annual household income less than $25,000 who receive a breast cancer screening based on most recent guidelines Target 78.4% Baseline 75.9% Baseline Year 2016 Data Source BRFSS Data Level state (by race/ethnicity, gender, and region), and by county 4.1.3 Increase the percentage of adults who receive a colorectal cancer screening	Socioeconomic - Target individuals without health insurance or who are under insured for Cancer Screening Services program.	4.1.1 Work with health care providers/clinics to put systems in place for patient and provider screening reminders (e.g., letter, postcards, emails, recorded phone messages, electronic health records (EHR) alerts).	Number of individuals screened for colon and/or breast cancer	Preventative outreach is currently in the form of a letter or post card. Feedback received has challenged the staff of ECH to develop a new way of connecting with individuals in need. Care coordination has began using phone calls as an opportunity to open the conversation about cancer screening. Reminder alerts are added to the EHR on individuals who may be overdue. A relationship has been established with Exact Science, a vendor for cologuard, the order form has been added into the EHR and generates once the provider adds the order.	ECH will develop a patient centered approach to preventative care outreach. Patient and Family Advisors will be involved in development of new outreach.	ECH will offer an increased number and locations of screening events throughout the year. Continued collaboration with the Cancer Screening Program and joint patient engagement will allow for positive patient outcomes. At least four events per year will hightlight cancer screening education.	Hospital	ECH will maintain documentation of outreach and a total number of individuals screened. Resources: https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/https://www.thecommunityguide.org/topic/cancer

Name of County - Organization(s) 2019 Workplan	Adirondack Health	Essex County Health Department	UVMHN Elizabethtown Community Hospital	North Country Healthy Heart Network	Champlain Valley Family Services	
Planning Report Liaison	Dan Hill, Heidi Bailey	Jessica Darney Buehler, Elizabeth Terry	Julie Tromblee, Amanda Whisher	Ann Morgan	Dana Bushy Isabella	
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Priority	Focus Area (select one from drop down list)	Goal Focus Area (select one from drop down list)	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s) and Resources
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.1 Increase cancer screening rates	4.1.3 - Increase colorectal cancer screening rates in Essex County from 66.9% to at least 68.5% to meet upstate NY colorectal cancer screening rate by December 2021.	Health Access, Education, Economic Stability Socioeconomic - Target individuals without health insurance or who are under insured for Cancer Screening Services program. Access - Having the ability to educate patients outside of the healthcare setting.	4.1.3 Use small media such as videos, printed materials (letters, brochures, newsletters) and health communications to build public awareness and demand.	Number of social media posts related to cancer screenings Input Measures: # of cancer screening social media posts, ads, and campaigns created Output Measures: # of cancer screening social media posts, ads, and campaigns posted/printed/promoted Short-term Outcome: increased cancer screening health communications Intermediate Outcome: increased # of residents who engage in cancer screening campaign/communications and # of locations materials were distributed. Long-term Outcome: increase in cancer screening referrals and screening events	ECH has an active social media presence where posts directed at cancer screening can be completed. Essex County Health Department collaborated with the Cancer Services Program (CSP) of Northeastern NY and International Paper for a 'Mowember' awareness campaign in November, 2019, . Educational flyers were distributed in public locations to raise awareness of the risks factors and how to prevent prostate and testicular cancers. The importance of regular screening was also highlighted. Materials on the Cancer Screening Program of Northeastern NY were distributed to assist employees that are uninsured or under insured. Essex County Health Department will also establish a baseline by researching social media logs and ad campaigns to determine current cancer screening campaign efforts.	ECHD and ECH will complete media campaigns together to address the need for cancer screening. Post cancer screening health messaging on the Essex County Health Department Facebook page to remind people of the importance of prevention and early detection. Create and print newspaper ads promoting the importance of cancer screening including targeted cancer screening public health observances (E.g. March - Colorectal Cancer Awareness). Collaborate with the CSP of Northeastern NY on awareness campaigns and assist in promoting scheduled screening events.	A calendar of events will be created an published for the public to plan screening on their availability. Post cancer screening health messaging on the Essex County Health Department Facebook page to remind people of the importance of prevention and early detection. Create and print newspaper ads promoting the importance of cancer screening including targeted cancer screening public health observances (E.g. March - Colorectal Cancer Awareness). Collaborate with the CSP of Northeastern NY on awareness campaigns and assist in promoting scheduled screening events.	Media	ECHD - collaborate with CSP Northeastern NY on creating educational materials using evidence-based interventions assist in distributing though various media outlets. CSP Northeastern NY - collaborate with ECHD on creating educational materials using evidence-based interventions and assist in distribution, collaborate with health networks to schedule and offer screening events Media - publish ads and disseminate information to Essex County residents. ECH will provide community outreach and education. Resources: https://www.thecommunityguide.org/topic/cancer
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.1 Increase cancer screening rates	4.1.1 Increase the percentage of women with an annual household income less than $25,000 who receive a breast cancer screening based on most recent guidelines Target 78.4% Baseline 75.9% Baseline Year 2016 Data Source BRFSS Data Level state (by race/ethnicity, gender, and region), and by county 4.1.3 Increase the percentage of adults who receive a colorectal cancer screening based on the most recent guidelines (ages 50 to 75 years) Target 80.0%	Socioeconomic - Target individuals without health insurance or who are under insured for Cancer Screening Services program. Access - Having the ability to educate patients outside of the healthcare setting.	4.1.4 Work with clinical providers to assess how many of their patients receive screening services and provide them feedback on their performance (Provider Assessment and Feedback).	Number of individuals screened for colon and/or breast cancer	Due to expectations of the Accountable Care Organization and National Committee for Quality Assurance, ECH maintains month values of breast and colon cancer screenings that are provided to the provider quarterly.	ECH will increase provider awareness through the completion of monthly education and review of provider standings.		Hospital	Resources: https://www.thecommunityguide.org/topic/cancer
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.1 Increase cancer screening rates	4.1.1 Increase the percentage of women with an annual household income less than $25,000 who receive a breast cancer screening based on most recent guidelines Target 78.4% Baseline 75.9% Baseline Year 2016 Data Source BRFSS Data Level state (by race/ethnicity, gender, and region), and by county 4.1.3 Increase the percentage of adults who receive a colorectal cancer screening based on the most recent guidelines (ages 50 to 75 years) Target 80.0% Baseline 68.5%	Socioeconomic - Target individuals without health insurance or who are under insured for Cancer Screening Services program. Access - Having the ability to educate patients outside of the healthcare setting.	4.1.5 Remove structural barriers to cancer screening such as providing flexible clinic hours, offering cancer screening in non-clinical settings (mobile mammography vans, flu clinics), offering on-site translation, transportation, patient navigation and other administrative services and working with employers to provide employees with paid leave or the option to use flex time for cancer screenings.	Number of individuals screened for colon and/or breast cancer	ECH currently offers screening events at the Elizabethtown and Ticonderoga sites at a minimum of four times per year.	ECH will expand cancer screening events and will continue to work with partner organizations to increase awareness.	ECH will work with Cancer Screening services to promote screening within the health centers.	Hospital	ECH will keep documentation on the number of screenings. Resource https://www.thecommunityguide.org/topic/cancer
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.1 Increase cancer screening rates	4.1.1 Increase the percentage of women with an annual household income less than $25,000 who receive a breast cancer screening based on most recent guidelines Target 78.4%	Socioeconomic - Target individuals without health insurance or who are under insured for Cancer Screening Services program. Access - Having the ability to educate patients outside of the healthcare setting.	4.1.6 Ensure continued access to health insurance to reduce economic barriers to screening.	Number of insured vs uninsured patients	Elizabethtown Community Hospital welcomes organizations such as Adirondack Health Institute on site to assist patients in identifying and securing health insurance.	Increase the number of locations representatives are present.	Increase the number of days annually representation is on site.	Hospital	ECH will maintain a record of dates and locations partners were on site for insurance navigation. Resources - https://www.thecommunityguide.org/topic/cancer
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity	4.2.1 Increase the percentage of adults 45+ who had a test for high blood sugar or diabetes within the past three years by 5% Target 71.7% Baseline 68.3% Baseline Year 2016 Data Source BRFSS Data Level state (by gender, income, and region), and by county Increase the percentage of adults 45+ who had a test for high blood sugar or diabetes within the past three years by 5%	Socioeconomic - Target individuals without health insurance or who are under insured for screening services. Access - Having the ability to educate patients outside of the healthcare setting.	4.2.1 Promote strategies that improve the detection of undiagnosed hypertension in health systems	Number of individuals screened for HTN Policy/practices to identify at-risk patients . % of patients with improved HbA1c, weight loss and physical activity measure. Promote referrals of patients to chronic disease wellness coaches. Policy/practices to identify at-risk patients . % of patients with improved HbA1c, weight loss and physical activity measure. Promote referrals of patients to chronic disease wellness coaches.	Both emergency departments are linked to The University of Vermont Health Network via high-tech telemedicine capabilities. During a stroke or other critical care case, physicians confer with trauma teams at the UVM Medical Center, a level 1 trauma center with specialists in all major medical and surgical fields available to assist when needed. Utilize electronic health records and HIXNY to gather patients lists to identify individuals with undiagnosed hypertension and pre-diabetes	ECH will expand health screenings to all eight sites. There will be increased attention to public education pertaining to stroke. Policies/practices in place for providers,nurses and medical office assistants to promote and detect chronic diseases	Identify chronic disease self management educator and host education session. ECH will increase the number of screening events completed annually. ECH will be recognized as an Acute Stroke Ready Hospital by Joint Commission.	Hospital	Health system grantee will provide staff time to support practice enhancement activities aimed at increasing identification and diagnosis of pre-diabetes offer practice facilitator staff time to support use of registry and staff time to support development. Will also support with funds to pay for patient education material. Franklin County Public Health Department will assist by increasing access to care by acting as a referral mechanism for chronic disease wellness coaching.
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.3 Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	4.2.1 Increase the percentage of adults 45+ who had a test for high blood sugar or diabetes within the past three years by 5% Target 71.7% Baseline 68.3% Baseline Year 2016 Data Source BRFSS Data Level state (by gender, income, and region), and by county	Socioeconomic - Target individuals without health insurance or who are under insured for screening services. Access - Having the ability to educate patients outside of the healthcare setting.	4.2.2 Promote testing for prediabetes and risk for future diabetes in asymptomatic people in adults of any age with obesity and overweight (BMI 25 kg/m2 or 23 kg/m2 in Asian Americans) and who have one or more additional risk factors for diabetes, including first degree relative with diabetes, high risk race/ethnicity, and history of cardiovascular disease. Promote testing for all other patients beginning at 45 years of age. Promote repeat testing at a minimum of 3-year intervals, with consideration of more frequent testing depending on initial results and risk status.	Number of individuals screened for diabetes and Number of referrals to diabetic education	Certified Diabetic Educator (CDE) actively sees patients in primary care health centers for ECH in addition to the Elizabethtown and Ticonderoga sites and advocates for all patients. CDE has excellent working relationship with providers. Certified Diabetic Educator (CDE) attends at least 50% of health fairs and promotes pre-diabetes screening. The CDE provides education and educational materials at time of screening.	Promotion of the Diabetic Education will continue. Support groups will be held monthly at both ECH and Ticonderoga campuses.	The hospital will continue to develop the program and identify opportunities to increase the access to diabetic education for patients of health centers where transportation is a barrier.	Hospital	Resources - https://www.cdc.gov/sixeighteen/diabetes/index.htm
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.3 Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	4.2.1 Increase the percentage of adults 45+ who had a test for high blood sugar or diabetes within the past three years by 5% Target 71.7% Baseline 68.3% Baseline Year 2016 Data Source BRFSS Data Level state (by gender, income, and region), and by county	Socioeconomic - Target individuals without health insurance or who are under insured for screening services. Access - Having the ability to educate patients outside of the healthcare setting. Income, Access, Care Coordination.	4.3.1 Promote a team-based approach (which may include pharmacist, community health worker, registered dietitian, podiatrist, and other health workers) to chronic disease care to improve health outcomes.	Number of patients referred to the Diabetes Prevention Program. Policy/practices to identify at-risk patients . % of patients with improved HbA1c, weight loss and physical activity measure. Promote # referrals of patients to chronic disease wellness coaches.	Patients who are identified to have the diagnosis of diabetes or prediabetes will be referred to the care team for further management. Identify undiagnosed pre-diabetic through electronic health records. Monitor patients with quality dashboard.	Individuals identified will be referred to appropriate programs (wellness program, wellness Rx, Diabetic Education, or Diabetes Prevention Program). Conduct in-service education to medical staff for further expansion of chronic disease prevention program.	Referrals to available programs will increase by ten percent. Increase access to chronic disease wellness coaches to schools and worksites.	Hospital	Health system grantee will partner and support this intervention with staff time to support practice enhancement activities aimed at increasing referral of patients to DPP program. Additionally, assist with funds for patient education and DPP facilitator training. Franklin County Public Health Department will assist by increasing access to care by acting as a referral mechanism for diabetes prevention program. ECH will maintain records of individuals screened and referred to programs.
	Focus Area 4: Preventive care and management	Goal 4.3 Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	Decrease the percentage of adult members with diabetes whose most recent HbA1c level indicated poor control (>9%)	Income, Access, Care Coordination	4.3.5 Promote referral of patients with prediabetes to an intensive behavioral lifestyle intervention program modeled on the Diabetes Prevention Program to achieve and maintain 5% to 7% loss of initial body weight and increase moderate-intensity physical activity (such as brisk walking) to at least 150 min/week.	Policy/practices to identify at-risk patients . % of patients with improved HbA1c, weight loss and physical activity measure. Promote # referrals of patients to chronic disease wellness coaches.	Identify undiagnosed pre-diabetic through electronic health records. Monitor patients with quality dashboard.	Conduct in-service education to medical staff for further expansion of chronic disease prevention program.	Increase access to chronic disease wellness coaches to schools and worksites.	Community-based organizations	Health system grantee will partner and support this intervention with staff time to support practice enhancement activities aimed at increasing referral of patients to DPP program. Additionally, assist with funds for patient education and DPP facilitator training. Franklin County Public Health Department will assist by increasing access to care by acting as a referral mechanism for diabetes prevention program.

Name of County - Organization(s) 2019 Workplan	Adirondack Health	Essex County Health Department	UVMHN Elizabethtown Community Hospital	North Country Healthy Heart Network	Champlain Valley Family Services	
Planning Report Liaison	Dan Hill, Heidi Bailey	Jessica Darney Buehler, Elizabeth Terry	Julie Tromblee, Amanda Whisher	Ann Morgan	Dana Bushy Isabella	
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Priority	Focus Area (select one from drop down list)	Goal Focus Area (select one from drop down list)	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s) and Resources
	Focus Area 4: Preventive care and management	Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	Increase the percentage of adults with chronic conditions (arthritis, asthma, CVD, diabetes, CKD, cancer) who have taken a course or class how to learn how to manage their condition.	Income, Access, Disability	4.4.2 Expand access to chronic disease self management	Number of patients who participate in NDPP. Number of patients who complete NDPP. Number of educators certified. Number of locations to hold NDPP classes.	Chronic disease wellness coaches certified to administer NDPP classes in 2020.	Track number of patients. Additional locations sites identified to increase access to classes.	Continue to track number of patients. Additional locations sites identified to increase access to classes.	Local health department	Health system grantee will provide staff time to support establishment and/or maintenance of DPP programs. This includes facilitator training, stipends and participant materials. Health System grantee will also assist with data collection and reporting, as required by CDC to maintain recognition. Franklin and Essex County Public Health Department will promote NDPP classes to their population.
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	Increase the percentage of adults with chronic conditions (arthritis, asthma, CVD, diabetes, CKD, cancer) who have taken a course or class how to learn how to manage their condition. 4.4.1 Increase the percentage of adults with chronic conditions (arthritis, asthma, CVD, diabetes, CKD, cancer) who have taken a course or class to learn how to manage their condition Target 10.60% Baseline 10.1% Baseline Year 2016 Data Source BRFSS Data Level state (by gender, age, race/ethnicity, income), and by county	Socioeconomic - Target individuals without health insurance or who are under insured for screening services. Access - Having the ability to educate patients outside of the healthcare setting.	4.4.3 Expand access to the National Diabetes Prevention Program (National DPP), a lifestyle change program for preventing type 2 diabetes.	Number of participants in the DPP program Number of patients who participate in NDPP. Number of patients who complete NDPP. Number of educators certified. Number of locations to hold NDPP classes.	An identified staff member will complete DPP training to become a certified life coach.	ECH will continue to develop and enhance a DPP program. Screening events will continue to be held regularly at various sites.	A DPP program will be developed and put into place by January 2021.	Hospital	ECH will maintain a total number of participants in the DPP program as well as results following the completion of the patient's participation. Health system grantee will provide staff time to support establishment and/or maintenance of DPP programs. This includes facilitator training, stipends and participant materials. Health System grantee will also assist with data collection and reporting, as required by CDC to maintain recognition. Franklin and Essex County Public Health Department will promote NDPP classes to their population.

Name of County - Organization(s) **2019 Workplan**	Adirondack Health	Essex County Health Department	UVMHN Elizabethtown Community Hospital	Schroon Lake Pharmacy	The Prevention Team	Essex County Sheriff					
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Priority	Focus Area	Goal	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s) and Resources
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 1: Promote Well-Being	Goal 1.1 Strengthen opportunities to build well-being and resilience across the lifespan	1.1.2.3 Reduce the adult New Yorkers with incomes between $15,000 to $74,000 New Yorkers reporting frequent mental distress during the past month by 10% to no more than 21.8% Target 21.8%	Access - The rural setting limits individuals from accessing services and programs outside of their communities.	1.1.4 Integrate social and emotional approaches across the lifespan. Support programs that establish caring and trusting relationships with older people. Examples include the Village Model, Intergenerational Community, Integrating social emotional learning in schools, Community Schools, parenting education	Number of Specialty services added	Continue to build upon the medical village in Ticonderoga. Primary Care to be available by 2021.	ECH will continue to explore Dental, Opthalmology and Gynecology in the Ticonderoga campus.	ECH will work with the Care Delivery Optimization Team	Hospital	https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Mental-Health
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 1: Promote Well-Being	Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan	Achieve Health System goal of becoming an age friendly institution with the 4M's framework from IHI; Reduce the percentage of adults 65+ New Yorkers reporting frequent mental distress during the past month by 10% to no more than 13%.	Income, Access, Disability	1.2.3 Policy and program interventions that promote inclusion, integration and competence (Age Friendly)	Number of patients with advance care planning in place, number of patients with who have had fall risk screen using STEADI assessment on all patients over 65 and referred to PT as needed.Number of patients over age 65 screened for depression using PHQ-9 assessment	Implement policy and procedure within the Emergency department. Implement structured fields in hospital electronic medical records to assess 4M's- Mentation, Medication, What Matters and Mobility	Complete assessment of health centers and identify needs. Create a plan for implementation of Age Friendly initiative and work with Nurse Manager to build annual wellness assessment to include the 4 M's. Work with medical staff to incorporate what Matters into their progress note.	Review the assessment data to ensure proper documentation is completed. Speak with staff about the effectiveness and workflow while entering assessments. Review and revise assessments and documentation based on feedback from patients and staff.	Local health department	Mercy Care for the Adirondack will support by communicating efforts to the region, provide expertise. Franklin County Public Health will provide support and help identify seniors at risk of negative health outcomes that can benefit from hospital services. Franklin and Essex County Office of the Aging will further provide expertise, referrals and assistance with programming to improve well-being.
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.1 Prevent underage drinking and excessive alcohol consumption by adults	2.1.1 Reduce the percentage of youth in grades 7-12 reporting the use of alcohol within the past 30 days by 10% from 25.8 in 2018 to 23.22% in 2020 .	Education , Social & Community Context	2.1.2 Implement School based prevention: Implement/Expand School-Based Prevention Services. Life Skills Training (LST) is a school-based program that aims to prevent alcohol, tobacco, and marijuana use and violence by targeting major social and psychological factors that promote the initiation of substance use and other risky behaviors	Input: The Prevention Team will pilot Life Skills 3-6 Curriculum in four of the ten school they are providing services in. Output: Approximately 50 - 100 students will receive this training by December 2021. Short term: students will complete a Pretest prior to the Life skills Curriculum to assess current knowledge Intermediate: The Essex County Prevention Team will train four (4) school educators in the Life Skills 3-6 Curriculum Long-term: Students will complete a posttest measuring knowledge gained	The Essex County Prevention Team will train four (4) school educators in the Life Skills 3-6 Curriculum. The Prevention Team will pilot Life Skills 3-6 Curriculum in four of the NINE (9) school they are providing services in.	The Essex County Prevention Team will implement Life skills Curriculum in 5 out of the 9 nine schools	The Essex county Prevention Team will Implement life Skill in 9 out of the 9 schools.	Community-based organizations	The Prevention team will provide the Life skills training Schools will provided time in their Curriculum
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2 Prevent opioid overdose deaths	2.1.2 Reduce the age-adjusted percentage of adult (age 18 and older) binge drinking (5 drinks or more for men during one occasion, and 4 or more drinks for women during one occasion) during the past month by 10% to no more than 16.4%	Access - The rural setting limits individuals from accessing services and programs outside of their communities.	2.1.5 Implement Screening, Brief Intervention, and Referral to Treatment (SBIRT) Electronic screening and brief interventions (e-SBI) using electronic devices (e.g., computers, telephones, or mobile devices) to facilitate delivery of key elements of traditional SBI	Number of positive screens	All health centers nursing staff have been trained on SBIRT.	ECH will continue to screen patients annually and make the necessary referrals for treatment.	Number or referrals to the care team will increase. Complex cases to be dicussed during care team meetings to explore necessary interventions.	Hospital	St. Joseph's Outpatient Rehabiliation
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.1: Strengthen opportunities to build well-being and resilience across the lifespan	2.1.2 Reduce the age-adjusted percentage of adult (age 18 and older) binge drinking (5	Socioeconomic	2.1.6 Integrate trauma-informed	Dates of trainings offered and number of attendees	Trauma informed care training to be offered to hospital	Medical officer to extend formal invitation to providers to	Training will be expanded to nursing and clinical staff.	Hospital	AHI & UVHN
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.1: Strengthen opportunities to build well-being and resilience across the lifespan	2.1.2 Reduce the age-adjusted percentage of adult (age 18 and older) binge drinking (5 drinks or more for men during one occasion, and 4 or more drinks for women during one occasion) during the past month by 10% to no more than 16.4%	Socioeconomic Access - Having the ability to educate patients outside of the healthcare setting.	approaches and responses into prevention programs by training staff, developing protocols and engaging in cross-system collaboration		and health center providers.	attend offered training events.			
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2 Prevent opioid overdose deaths	2.2.2 Increase the age-adjusted Buprenorphine prescribing rate for substance use disorder (SUD) by 20% to 43.8 per 1,000 population. Baseline: 36.5 per 1,000	Socioeconomic Access - Having the ability to educate patients outside of the healthcare setting.	2.2.1 Increase availability of/access and linkages to medication-assisted treatment (MAT) including Buprenorphine	Number of MAT prescribers	ECH has two providers currently able to prescribe for MAT.	ECH will increase the number of providers to three.	ECH will explore the option of having physician assistants become x-waivered to be able to prescribe MAT.	Hospital	NYSDOH
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2 Prevent opioid overdose deaths	2.2.4 Reduce all emergency department visits (including outpatients and admitted patients) involving any opioid overdose, age-adjusted rate by 5% to 53.3 per 100,000 population	Socioeconomic Access	2.2.2 Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers	Number of kits provided. Number of opioid ED encounters referred to open access clinic, number of users prescribed Buprenorphine. Number of provider education classes taken. Number of prescription drugs obtained in safe disposal boxes.	Narcan kits are availble for community members at the Ticonderoga and Elizabethtown campuses. Narcan available at all Emergency Departments and Health Centers. Safe Disposal site located on campus.	Evaluate the number of kits dispensed to community members. Complete another Public Information advertisment to ensure community is aware of the service. Provide annual medical staff in service education.	Evaluate the number of kits dispensed. Advertise availability. Have a clinical staff member present and dispense at our annual Community Fair. Provide annual medical staff in service education.	Hospital	Alliance for Positive Health St. Josephs Addiction Treatment Center will partner with hospital to provide continued care coordination and information sharing to ensure patients receive the appropriate level of care.
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2 Prevent opioid overdose deaths	2.2.4 Reduce all emergency department visits (including outpatients and admitted patients) involving any opioid overdose, age-adjusted rate by 5% to 53.3 per 100,000 population	Access	2.2.3 Promote and encourage prescriber education and familiarity with opioid prescribing guidelines and limits as imposed by NYS statutes and regulations	Number of opioid prescriptions	Opioid stewardship	Prescribing patterns will be analyzed and education provided. Pharmacy to be included during health fairs to provide education to the community regarding opioid prescribing guidelines.	Attend Essex county Heroin and Opioid Taskforce (ECHO).	Hospital	NYS Bureau of Controlled Substances. ECHO
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2 Prevent opioid overdose deaths	2.2.1 Reduce the age-adjusted overdose deaths involving any drug from the Essex County rate 18.4/100K to the North Country rate of 11.3/100K or better.	Socioeconomic Access Social and Community	2.2.5 Establish additional permanent safe disposal sites for prescription drugs and organized take-back days	Number of sites and dates of take backs Input: *Identify a location in Southern Essex County that will install a medication drop box. *Identify location sites for take back days Output: *Increase the number of medication drop boxes in the southern part of Essex County by at least one (1). * Schedule take-back days Short- term: The pharmacy will track utilization and report back. On social media we will count the views and engagement of the take back campaign Intermediate: Increase the amount of medication reported to have been dropped in box by pharmacy Create a media campaign to raise awareness of the new drop box as well as all existing Drop Boxes. Increase awareness off take back day events count the amount of views and engagement. Long-term: Risk reduction by removing the unwanted medication from households we will : Reduce the percentage of youth in grades 7-12 reporting the use of alcohol within the past 30 days by 10% from 25.8 in 2018 to 23.22% in 2020 .	Take back dates will now be listed during health fairs to promote the bins located in the lobby at both the Ticonderoga and Elizabethtown campus. ECHD will meet with (1) Southern Essex County Pharmacy . ECHD will contact the DEC and become educated on medication drop box Pilot Pharmaceutical Take-Back Program.	Social media highlights will be present to increase utilization of the safe disposal sites. ECHD will support the pharmacy in arranging for the delivery and installation of the medication drop box. The pharmacy will design a schedule in which medication is removed from the box and prepared for shipment to the DEC for incineration. The pharmacy will quantify the medication being shipped in a report to the ECHD. ECHD will design a media campaign to alert the public of the new drop location. Views and engagement will be tracked. ECHD will support the Prevention Team and the Sheriffs office with a social media campaign to promote drug take back days in April and December.	Evaluate the need for safe disposal sites at outlying health centers due to lack of transportation. The pharmacy will increase the quantity of the medication being shipped in a report to the ECHD. ECHD will collect data on the media campaign to alert the public of the new drop location and all existing ones. Views and engagement will be tracked. ECHD will support the Prevention Team and the Sheriff's office with a social media campaign to promote drug take back days in April and December. Views and engagement will be tracked.	Hospital	Schroon Lake Pharmacy- Drop box location Essex County Health Department- Media Campaign Essex County Sheriff dept. Take back event The Prevention Team supports Take Back event. NYSDEC.

Name of County - Organization(s) 2019 Workplan	Adirondack Health	Essex County Health Department	UVMHN Elizabethtown Community Hospital	Schroon Lake Pharmacy	The Prevention Team	Essex County Sheriff						
Planning Report Liaison	Dan Hill, Heidi Bailey	Linda Beers	Julie Tromblee, Amanda Whisher	Rebcca Doyle	Doug Turbeek	David Reynolds						
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Priority	Focus Area	Goal	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s) and Resources
		Goal 2.6 Reduce the mortality gap between those living with serious mental illnesses and the general population	Decrease by 20% the prevalence of cigarette smoking among adults who are diagnosed with serious mental illness to 27.4%	Income, Access, Disability	2.6.2 Integrated treatment: Concurrent therapy for mental illness and nicotine addiction have the best outcomes.	Number of mental health patients referred to tobacco cessation counselor, number of tobacco users referred to mental health counseling.	Established on-site Open Access Clinic with St. Joseph's Addiction Treatment Center.			Hospital	St. Josephs Addiction Treatment Center will partner with hospital to provide continued care coordination and information sharing to ensure patients receive the appropriate level of care.

Name of County - Organization(s) Adirondack Health Essex Coutny Health Department
2019 Workplan

Planning Report Liaison Dan Hill, Heidi Bailey Susan Allott
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Priority	Focus Area	Goal	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s) and Resources
Promote Healthy Women, Infants and Children	Focus Area 2: Perinatal and Infant Health	Goal 2.1: Reduce infant mortality and morbidity	Increase the percentage of women receiving early prenatal care by 4% (currently 71.4%) to 75.4% .	Adult literacy and higher educational attainment, transportation and annual household cost	Apply the Home Visiting Evidence of Effectiveness (HOMVEE) review to the current Essex County Health Department (ECHD) Family Health (FH) Home visiting program.	Input measures - HOMVEE review by FH staff and the Director of the Preventive Services (DPrevS) . Output measures - FH staff and DPrevS completed HOMVEE review and documented comparison with ECHD FH program and next steps. Short-Term Outcome - Develop recommendations for ECHD FH program improvement to better meet HOMVEE model of implementation. Intermediate Outcome - Update FH client educational materials, including childbirth education (CBE) and visitation format to best match evidence based program. Long-term outcome - identify gaps and barriers to home visiting services.	The DPrevS attended the 11/15/19 Home Visiting Summit hosted by the Birth to 3 Collaborative. The 5 counties represented worked in groups to brainstorm priorities for the North Country region to submit to the NYSDOH Division of Family Health. This input is planned to be applied to the statewide needs assessment to inform our Title V Maternal and Child Health Services Block Grant program, which focuses on improving the health and well-being of mothers and children, including children and youth with special health care needs, and their families.	Continue to work with the Birth to 3 Collaborative to identify barriers and gaps in home visiting services. Collaborate with Adirondack Health to provide access to childbirth classes in Essex County.	Develop/revise an Essex County Resource List for expectant families and families with children ages birth to 3 and develop a plan to engage providers and community agencies with case management and referral to home visiting programs and other resources, such as lactation consultation and childbirth education classes and access to various methods of birth control.	Community-based organizations	Referral of eligible families to home visiting programs and other resources, such as WIC, Children's Services, ACAP Early Head Start and Head Start and Childbirth Education classes.
Promote Healthy Women, Infants and Children	Focus Area 3: Child and Adolescent Health, including children with special health care needs (CSHCN)	Goal 3.3: Reduce dental caries among children	Increase the percentage of children ages 1-17 years who had one or more preventive dental visits in the past year by 10% to 85.4%.	Poverty, transportation and built environment (access to Medicaid dental providers).	Integrate oral health messages and evidence-based prevention strategies within community-based programs serving women, infants, and children.	Input measures - ASTDD Oral Health Educational Resources for Home visitors and Families, and Best Practice Approach Reports. Output Measures - FH staff and DPrevS document evidence based measures best suited to align with Essex County WIC, Adirondack Community Action Program (ACAP) Head Start (HS) and Early Head Start (EHS) and ECHD Children's Services (CS) programs. Short Term Outcomes - WIC, ACAP EHD and HS and CS programs document # of children ages 0 to 5 years accessing a dental provider. Intermediate Outcomes - # of participants accessing evidence based measures, including a list of available dental providers and dental referral assistance as indicated. Long-Term Outcomes - Increase in the % of children served by ACAP HS and EHS, WIC and CS programs that access a dental provider.	No activities projected to be completed by the end of 2019.	Reach out to the New York State Department of Health (NYSDOH) Bureau of Child Health to collaborate on oral health messaging and outreach materials. Collaborate with ACAP, WIC and CS to assess current oral health strategies and those evidence-based strategies that can compliment or supplement what is currently being used.	Assess dental health of all participants in the ACAP, WIC and ECHD CS programs and provide referrals to dental providers as indicated	Community-based organizations	ACAP, WIC and Children's Services attend annual meeting with ECHD FH staff and DPrevS to determine current resources, best match evidence based resources, method of data collection and referral system.
Promote Healthy Women, Infants and Children		Goal 4.1 : Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes, and promote health equity for maternal and child health populations	4.1 - Increase and enhance collaboration with other programs, providers, agencies, and community members to address key social determinants of health that impact the health of women, infants, children, and families through bi-monthly (12 meetings total) coalition meetings through December 2021.	Healthcare Access	Enhance collaboration with other programs, providers, agencies, and community members to address key social determinants of health that impact the health of women, infants, children, and families across the life course using evidence-based interventions.	Input Measures: # of community based partners invited Output Measures: # of community based partners engaged Short-term Outcome: # of coalition meetings scheduled Intermediate Outcome: # of collaborations with partners that address social determinants of health impacting women, infants, children, and families. Long-term Outcome: Identify racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations	The Essex County Breastfeeding Coalition will re-brand to be more inclusive of other SDOH priority areas and issues currently impacting the health of women, infants, children, and families.	The coalition will review community health assessment data to determine priority areas and create a work plan based on identified objectives. Coalition members will provide bi-monthly updates on work plan objectives.	The coalition will review 2020 work plan data and provide input on objectives. The coalition will update the work plan based on progress and newly identified priorities.	Community-based organizations	ECHD - Schedule and facilitate coalition meetings in addition to the roles listed below. Elizabethtown Community Hospital (ECH), ACAP, Creating Breastfeeding Friendly Communities (CBFC) grant, Essex County WIC, Essex County Health Department - Children's Services Unit, and other community partners - assist in gathering data, provide input on priority areas, assist in completing identified work plan objectives to target identified disparities and barriers to addressing services to address SDOH.